

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8018369	
												REG. NO.	
1 - FOR STATE REGISTRAR													
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
<i>Henry John Bellmyer, Sr.</i>						<i>July 22, 1980</i>						<i>4:15 AM</i>	
3. SEX			4 RACE		5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)			# UNDER 1 YEAR	# UNDER 24 HRS			
<i>Male</i>			<i>White</i>		<i>July 31, 1904</i>	75			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.		
<i>Maryland</i>			<i>USA</i>					<i>Hartford</i>					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY				
<i>Havre de Grace</i>			<i>Hartford Mem Hospital</i>			<i>Auto Mechanic</i>			<i>US-govt. Ret.</i>				
13a STATE			13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS				
<i>Md</i>			<i>Hartford</i>		<i>Md. Joppa</i>				<i>817 Magnolia</i>				
14 FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST	ADDRESS			
<i>Charles</i>				<i>Bellmyer</i>	<i>Mary</i>					<i>Kammerer</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT			18 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
<i>NO</i>			<i>218-22-0762</i>			<i>Mrs. Hope Bellmyer, Joppa, Md.</i>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)													
<i>Cardio-pulmonary Arrest</i>													
5188 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Respiratory Failure</i>													
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Restrictive Lung Disease</i>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>MORBID OBESITY</i>													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <i>7-22 1980</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c DATE SIGNED <i>7/22/80</i>	
22b SIGNATURE <i>Dante W. Monakil, M.D.</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>							
22c PHYSICIAN'S NAME (TYPE OR PRINT) <i>DANTE W. MONAKIL, M.D.</i>			22d ADDRESS <i>622 Union Ave, Baltimore, Md.</i>										
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b DATE <i>July 24, 1980</i>			23c NAME OF CEMETERY OR CREMATORIAL Cemetery			23d LOCATION CITY OR TOWN <i>Joppa</i>			COUNTY	STATE
24 FUNERAL DIRECTOR NAME <i>Howard K. McComas III, Abingdon, Md.</i>			ADDRESS			25a DATE REC'D. BY REGISTRAR <i>JUL 24 1980</i>			25b REGISTRAR'S SIGNATURE <i>John McComas</i>				

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 18370					
1- STATE REGISTRAR			2a. DATE KNOWN OF ESTI- DEATH MATED									2d. HOUR					
(TYPE OR PRINT)			Henry			Herbert Bennett SR.			7 19 1980			M					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR.			IF UNDER 24 HRS.		
			M CauC			10 21 23			56 yrs.			MONTHS			DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			WIDOWED			NEVER MARRIED			DIVORCED		
W. Va.			USA			<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>			<input type="checkbox"/>			<input type="checkbox"/>		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Forest Hill			2213 Ady Road									Machinist			Metal		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
			Md			Harford			Forest Hill			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			2213 Ady Road		
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME											
			Claude V. Bennett						Della			FIRST MIDDLE LAST			Flo Molisee		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
no			217-20-5412			Harold J. Bennett, Fallston, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Self-inflicted gunshot wound of head</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS (CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a))																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?					
												YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion % death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <u>Willard P. Amoss</u>			TITLE (SPECIFY) M.D. <u>Post Deg.</u>			MEDICAL EXAMINER			DATE SIGNED <u>7/</u>								
EXAMINER'S NAME (TYPE OR PRINT) <u>Willard P. Amoss</u>			ADDRESS <u>2404 Pleasantville Rd, Fallston, Md</u>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>July 22, 1980</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>BelAir Mem. Gardens</u>			23d. LOCATION CITY OR TOWN <u>Bel Air</u>			COUNTY <u>Harford</u>			STATE <u>Md.</u>		
24. FUNERAL DIRECTOR NAME <u>Howard K. McComas III, Abingdon, Md</u>			ADDRESS			25a. DATE REC'D. BY REGISTRAR <u>JUL 22 1980</u>			25b. REGISTRAR'S SIGNATURE <u>Henry McComas</u>								
BP _____																	
DHMH - 17 (VR A15 ME (5))																	
15M7/77																	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

18371

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**1**  
**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. DECEASED-NAME (Type or print)				First	Middle	Last	20. DATE OF DEATH Month	2b. HOUR 5 45 AM	
<b>JAMES ARTHUR BILLINGSLEY</b>							7	5 45 AM	
3. SEX	4 RACE	5. DATE OF BIRTH			6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS		
MALE	NEGRA BLACK	1879 3-3-1971			99 101 YRS.	1	MIN.		
7b. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Md.	AMERICA USA				HARFORD				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
HAVRE DE GRACE	421 S. UNION AVE.			TAIEMER			FARMING		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER						
Md.	WHITE HALL	NO	NONE						
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last		
JOSEPH	S.	CORDERLY		NANCY	N	M	BILLINGSLEY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address 659 ELM ST.						
NO	218-18-0552	MARY M. JOHNSON - ABERDEEN, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cadupusuring Arrest</i> . APPROXIMATE INTERVAL Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause } DUE TO, OR AS A CONSEQUENCE OF <i>Minutes</i> (b) <i>renal Failure</i> DUE TO, OR AS A CONSEQUENCE OF <i>Weeks</i> (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
YES <input type="checkbox"/>		NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
(If either, notify medical examiner)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION	Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <i>8/17</i> , 19 <i>80</i> , to <i>+K</i> , 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>8/30</i> , 19 <i>80</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>BARRY A. WOHL</i>		22c. DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22d. DATE SIGNED <i>7/15/80</i>	
22d. PHYSICIAN'S NAME (Type) <i>BARRY A. WOHL</i>		22e. ADDRESS <i>131 S. Union Avenue Havre de Grace, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>9 July 1980</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Pine Grove Methodist Cem.</i>			23d. LOCATION (City or Town) (County) <i>White Hall Baltimore Md.</i>	(State)		
24. FUNERAL DIRECTOR <i>Tarring Funeral Home, P.A., Aberdeen, Md. 21001</i>		ADDRESS			25a. FILED BY REGISTRATION <i>JULY 19 1980</i>	25b. REGISTERED SIGNATURE <i>BARRY A. WOHL</i>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

18372

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 3  
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**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3  
should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept.  
of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH	2b. HOUR				
<b>CARMEN ERSELA BLACKBURN</b>							Month Day Year	12 42 M				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR				
<b>FEMALE</b>		<b>CAUCASIAN</b>		<b>9-2-1886</b>		<b>93</b>		MONTHS	IF UNDER 24 HRS.			
								DAYS	HOURS			
									MIN.			
7b. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.				
<b>NORTH CAROLINA U.S.</b>		<b>U.S. UNION HOME</b>				<b>HARTFORD</b>						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
<b>HAURE DeGRACE</b>			<b>Brevin Nursing Home</b>			<b>House-wife</b>						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER			
<b>Md.</b>			<b>HARTFORD</b>			<b>Edgewood</b>			<b>304 Phila Rd.</b>			
14. FATHER'S NAME First Middle Lost			15. MOTHER'S MAIDEN NAME First Middle Lost									
<b>JONATHAN (NM) DeBOARD</b>			<b>SARILDA (NM) WEST</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			16c. INFORMANT			Address <b>2304 Phila Rd.</b>			
<b>no</b>			<b>818-54-2586</b>			<b>HARRISON-BLACKBURN</b>			<b>Edgewood - Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Car Sae stand still</b> 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Parkinsonism</b>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Fracture of spine by history</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
					YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>7-14</b> , 19 <b>80</b> , to <b>7-23</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>7-2</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											22c. DATE SIGNED <b>7/24/80</b>	
22b. SIGNATURE <b>Anne Donn pri</b>		22c. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										
22d. PHYSICIAN'S NAME (Type) <b>W. YAMAKAWA M.D. 319 So. Union Ave Hfd Md. 21078</b>		22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial July 25, 1980</b>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM <b>Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Abingdon, Hartford, Md.</b>						
24. FUNERAL DIRECTOR		ADDRESS			25a. REC'D BY REGISTRAR <b>JUL 25 1980</b>		25b. APPROVED <b>Howard K. McComas III, Abingdon, Md.</b>					
DHMH - 163/72 25M (VR A15 (4))												

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 1 8 3 7 3			
										REG. NO.			
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		July 6, 1980		11 <sup>32</sup> AM		
3. SEX <b>MALE</b>			4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mass.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford</b>						
10. CITY OR TOWN OF DEATH <b>Hause de Grace</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Harford Memorial Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chef</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>						
13a. STATE <b>MD</b>			13b. COUNTY <b>Cecil</b>		13c. CITY OR TOWN <b>Port Deposit</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>534 Craigtown Rd</b>				
14. FATHER'S NAME FIRST <b>Arthur</b> MIDDLE LAST <b>Bouret</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Adele</b> MIDDLE LAST <b>Thibedreau</b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO <b>1940-70</b>		17. INFORMANT <b>Helen L. Bouret, Port Deposit, Maryland.</b>		ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Inevitable Shock</b>													
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiopulmonary Arrest</b>													
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Heart Disease</b>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Diabetes Mellitus</b>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to July 6, 1980, that (I) (we) last saw the deceased alive on July 6, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.													
22b. SIGNATURE <b>Leticia S. Galvez</b>			22c. DEGREE <b>ms</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <b>7-7-80</b>				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Leticia S. Galvez</b>			22f. ADDRESS <b>S. Union Ave. Hause de Grace Md.</b>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>July 9, 1980</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National Cemetery, Arlington, Virginia</b>			23d. LOCATION CITY OR TOWN			COUNTY STATE	
24. FUNERAL DIRECTOR <b>Lee H. Patterson &amp; Son, Perryville, Maryland.</b>			ADDRESS			25. DATE REC'D. BY REGISTRAR <b>July 6, 1980</b>			25b. REGISTRAR'S SIGNATURE <b>J. Kennedy</b>				

11-2-5

✓ 11-2-5  
out of control

good ol' man  
tired  
will not stand up  
will just sit

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 8 3 7 4

1. DECEASED NAME (Type or print)	First	Middle	Lost	2a. DATE OF DEATH Month	Day	Year	2b. HOUR 1145PM	
ALICE	W.	Brawner		7	12	1980		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday) 74 YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN	
Female	Caucasian	6-7-1906	74					
7a. BIRTHPLACE (State or foreign country) Md	7b. CITIZEN OF WHAT COUNTRY? America	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Hartford					
10. CITY OR TOWN OF DEATH Havre de Grace	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 421 Union Ave. microfilm	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) microfilming	12b. KIND OF BUSINESS OR INDUSTRY Md.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md	13b. COUNTY Hartford	13c. CITY OR TOWN Edgewood	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 111 Hanson Road				
14. FATHER'S NAME Harry	First C.	Middle	Lost	15. MOTHER'S MAIDEN NAME Whitney Sadie	First	Middle	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO. 530-14-0527	17. INFORMANT WALTER Edmondson						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 CARDIAC ARREST								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO, OR AS A CONSEQUENCE OF ARTERIOSCLEROSIS								
stating the underlying cause (c) DUE TO, OR AS A CONSEQUENCE OF OLD AGE								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
MEDICAL CERTIFICATION								
21a. ACCIDENT WAS OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State			
22a. I certify that (I) (this hospital) attended the deceased from 1/26, 1980, to 1/12, 1980, that (I) (we) last saw the deceased alive on 1/21, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Dante Monakil		22c. DEGREE PHYS.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	DATE SIGNED 7/13/83		
22d. PHYSICIAN'S NAME (Type) DANTE MONAKIL		22e. ADDRESS 672 Union Ave Stamford Ct. Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 7/15/1980	23b. DATE 7/15/1980	23c. NAME OF CEMETERY OR CREMATORIAL Angel Hill Cemetery	23d. LOCATION (City or Town) Havre de Grace	(County) Harford	(State) Md.			
24. FUNERAL DIRECTOR Pennington & Son, 225 S. Washington	ADDRESS	25a. REC'D BY REGISTRAR Havre de Grace	25b. REGISTRAR'S SIGNATURE Henry Pennington					
DATE Jul 22 1980								

TABLE 1. USES OF THE PLATEAU



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8018375				
												REG. NO.				
1 - STATE REGISTRAR						2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	3. SEX			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)				
Florence			H.	Brown		Female			Month 3 Day 8 Year 1904			76 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN				
Mass.			USA						HARFORD							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			MD.				
HARFORD			HARFORD MEMORIAL HOSPITAL			Homemaker			Home							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Md.			Harford			HARFORD			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			814 MATHEWS Ave.				
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST				Locke			
James			B.	Harding	Anetta											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			Maryland 21001				
No			010-03-0034			Barbara L. Elder, 814 Matthews Ave., Aberdeen,										
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																
18. CAUSE OF DEATH (Enter only one cause per line for part 1a, (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5130 DUE TO, OR AS A CONSEQUENCE OF (b) NECKOTIZING PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5TROICE																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 6/1/80 to 7/14/80, that (I) (we) lost the deceased alive on 7/14/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. PHYSICIAN'S SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED							
Dante N. Monakil												7/18/80				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE			
Burial			7 July 1980			Bakers Cemetery			Aberdeen			Harford	Maryland			
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Tarring Funeral Home, P.A., Aberdeen, Md. 21001						JUL 9 1980						Lester Kennedy				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, these should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8018376			
										REG. NO.			
1 - STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			July 25, 1980			3 1/2 A.M.				
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS) BIRTHDAY		IF UNDER 1 YEAR				
Male		White		MAY 22, 1911			69		IF UNDER 24 HRS				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			YRS.			
Md.		U.S.A.					Harford			MONTHS DAYS HOURS MIN			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Havre de Grace		Harford Memorial Hosp.							CHIEF OFFICE, POSTAL SERVICE, RET.			MD.	
13a STATE		13b COUNTY		13c CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS				
Md.		Cecil		Perry Point			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Box 258-1102 Third Street				
14 FATHER'S NAME MIDDLE		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME						
Archer W.				Bullock			ELIZABETH MIDDLE		LAST				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT			18b. APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH						
No		217-06-2892		LAWRENCE C. BULLOCK - SAME									
18 CAUSE OF DEATH (Enter only one cause per line for Part I, II, and III) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)													
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
18c DUE TO, OR AS A CONSEQUENCE OF (b) Metastasis													
18d DUE TO, OR AS A CONSEQUENCE OF													
18e													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED							20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET		CITY OR TOWN		COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 7/23/80 to 7/25/80, that (I) (we) last saw the deceased alive on 7/25/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. DATE SIGNED 7/25/80			
22c. SIGNATURE Joan Yon Joan Yon										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS								22f. DATE SIGNED 7/25/80			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY STATE				
BURIAL		JULY 28, 1980		ANGEL HILL CEM.			HAVRE DE GRACE		BALTIMORE MD				
24 FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR								25b. REGISTRAR'S SIGNATURE			
R. Madison Mitchell, HAVRE DE GRACE MD.		JULY 29, 1980								Balby			

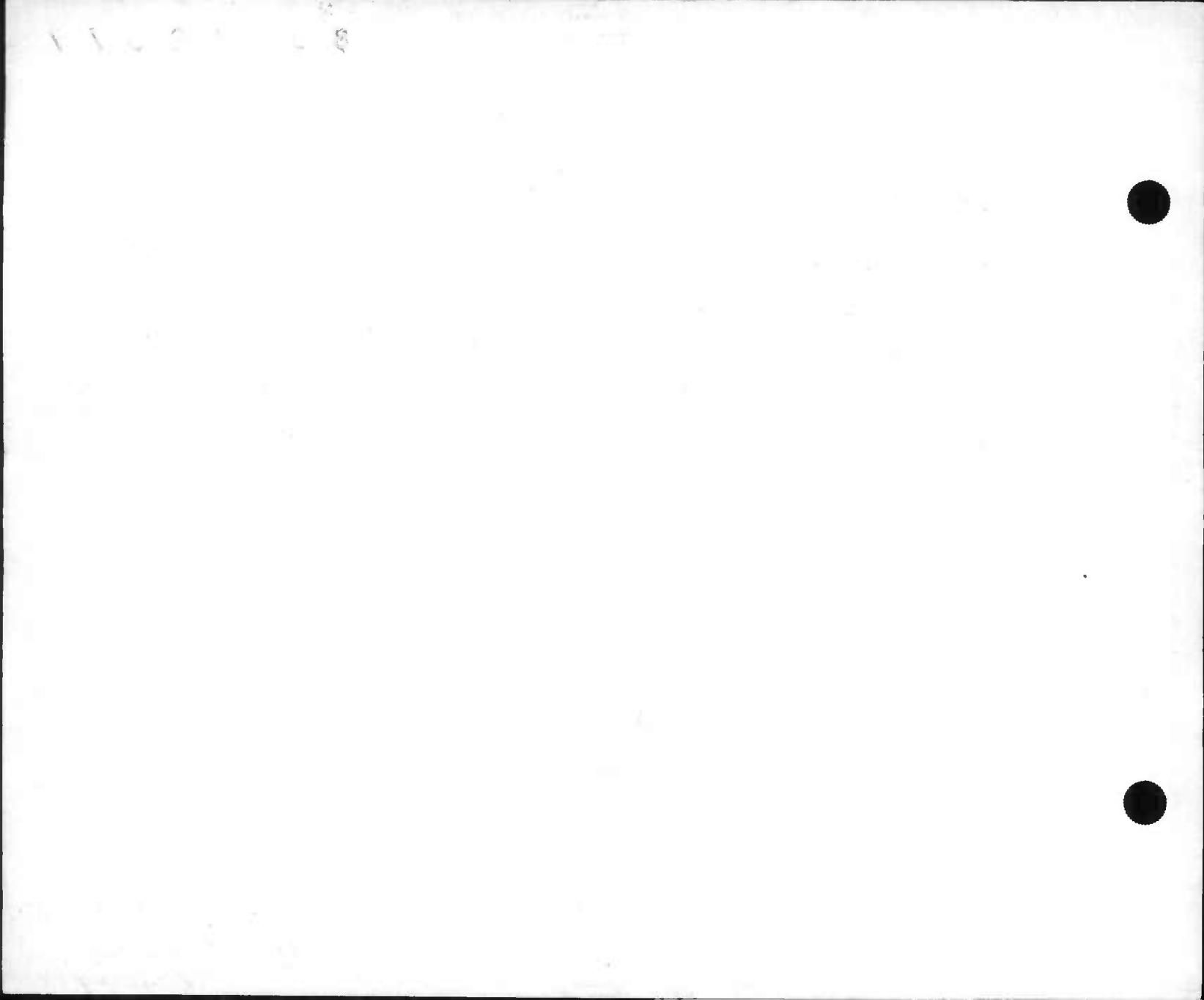
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8018377			
1 - STATE REGISTRAR			REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR	
Howard Willard Clark					Clark		July 7 1980					3:43 P.M.	
3 SEX			4 RACE	5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Male			Black	June 23, 1912			68						
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Virginia			USA				HARFORD						
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
HAURE de Grace			HARFORD Memorial Hospital			Farmer			Agriculture				
13a STATE			13b COUNTY	13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS			
MD			HARFORD	CHURCHVILLE						307 Asbury Rd.			
14 FATHER'S NAME FIRST			MIDDLE	LAST			15 MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST		
Howard Willard				Clark, Sr.			Eppie			--	Fields		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS				
No			228-26-9052			Mrs. Ida Mae Clark, Churchville, Md.							
18 CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
									YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a I certify that (I) (this hospital) attended the deceased from 7-7, 1980, to 7-7, 1980, that (I) (we) last saw the deceased alive on 7-7, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. DATE SIGNED			
22b SIGNATURE <i>J. deGlonde w/ d510 &amp; Son Jr</i>										DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>
22d PHYSICIAN'S NAME (TYPE OR PRINT) deGlonde w/ d510 & Son Jr										22e ADDRESS			
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY	STATE	
Removal			July 7, 1980			Hall F.H.			Purcellville-Loudoun-Virginia				
24 FUNERAL DIRECTOR NAME			ADDRESS			25a DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Howard K. McComas III, Abingdon, Md.						JUL 10 1980			<i>Henry McComas</i>				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

1 - STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 18378

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>James</i>	MIDDLE <i>Thomas</i>	LAST <i>Clark</i>	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> MONTH 7 YEAR 1980 2b. HOUR 2PM
3. SEX <i>M</i>	4. RACE <i>Caucasian</i>	5. DATE OF BIRTH MONTH 9 DAY 6 YEAR 25	6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.	IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN 0	IF UNDER 24 HRS. MONTHS 0 DAYS 0 HOURS 0 MIN 0	7c. DATE PRONOUNCED DEAD MONTH 7 DAY 12 YEAR 1980 24. HOUR 5PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford County</i>
10. CITY OR TOWN OF DEATH <i>Edgewood</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Bush River</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Truck Driver</i>	
13a. STATE <i>MD</i>	13b. COUNTY	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET ADDRESS <i>1830 St. Paul Street</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>	
14. FATHER'S NAME FIRST <i>Charles</i>		MIDDLE <i>Thomas</i>	LAST <i>Clark</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Unknown</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>228-16-7688</i>		17. INFORMANT <b>Widow:</b> <i>Betty H. Clark, 1830 St. Paul Street</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <i>Drowning, accidental</i> DUE TO, OR AS A CONSEQUENCE OF  { Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.  (b) <i>Alcoholism</i> DUE TO, OR AS A CONSEQUENCE OF  (c)						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>Alcoholism</i>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>William P. Amoss</i> M.D. <i>West Dept</i> MEDICAL EXAMINER EXAMINER'S NAME (TYPE OR PRINT) <i>William P. Amoss</i> ADDRESS <i>2404 Pleasantville Rd, Fallston MD 21047</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>7/17/80</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Westview Memorial Park</i>		23d. LOCATION CITY OR TOWN <i>Baltimore</i>	STATE <i>MD</i>
24. FUNERAL DIRECTOR NAME <i>STEWART &amp; MOWEN CO., 108 W. North Ave. 21201</i>		ADDRESS <i>15M 7/77</i>	25a. DATE REC'D. BY REGISTRAR <i>JUL 22 1980</i>		25b. REGISTRAR'S SIGNATURE <i>Patsy McCreedy</i>	



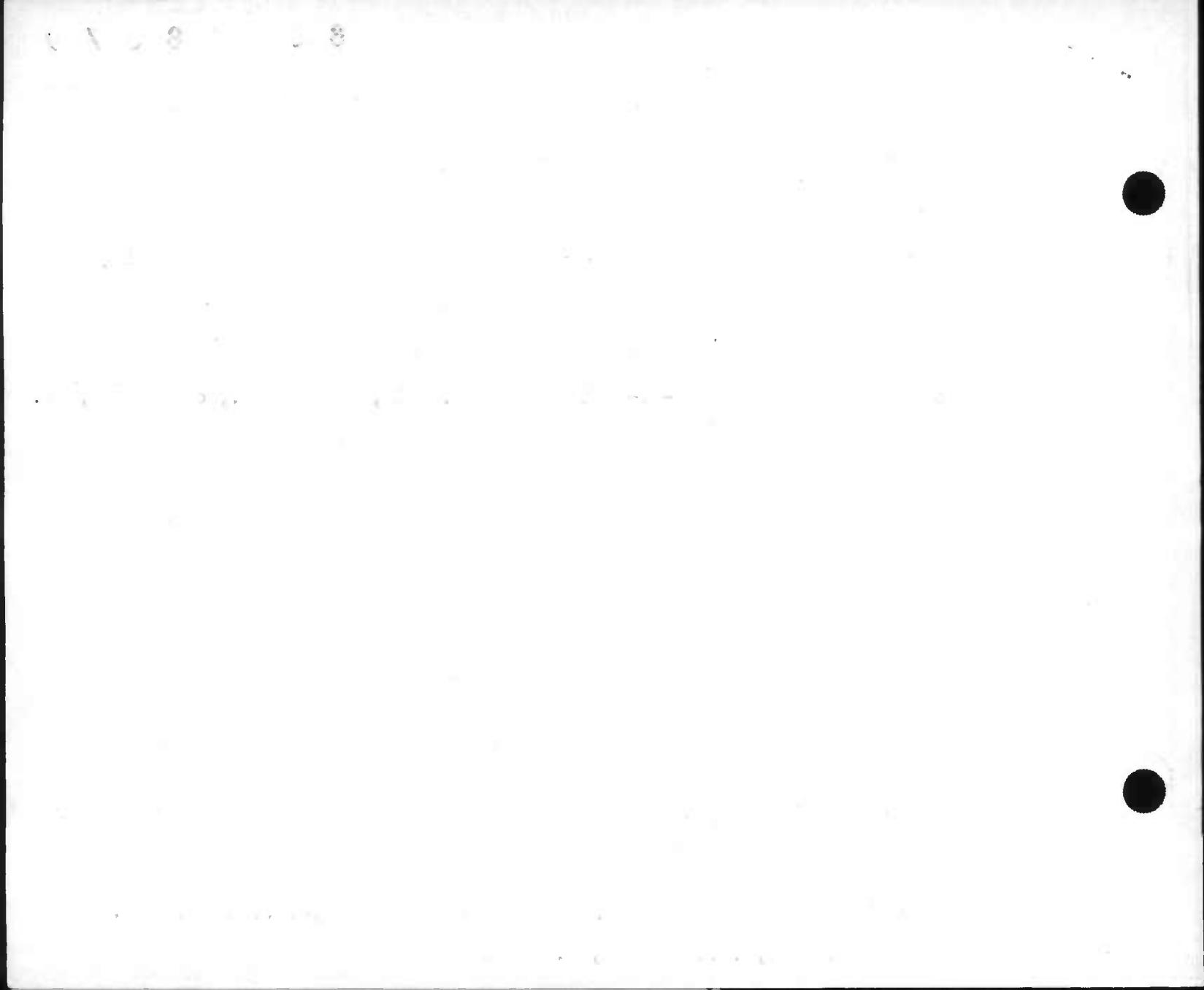
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8018379					
					REG. NO.					
1 - FOR STATE REGISTRAR	1. FIRST MIDDLE LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
	Graham Lewis Coale			July 20, 1980	6	20	AM	PM		
3. SEX	4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR	8. IF UNDER 24 HRS	
Male	White	MONTH	DAY	YEAR	YRS	MONTHS	DAYS	HOURS	MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
8a. Va.	U.S.A.			Hartford			Hartford			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Havre de Grace	Hartford Mem. Hospital					Farmer			Farming	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
Md	Hartford	Forest Hill	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			2246 Ady Rd.			21050	
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST			
Reeves		Coale	Ellen				Hall			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
No	221-01-5771			Curtis R. Coale, 2246 Ady Rd., Forest Hill, Md.						21050
18. CAUSE OF DEATH (Enter only one cause per line for Part 1, 1b, 1c, 1d, 1e, 1f, 1g, 1h, 1i, 1j, 1k, 1l, 1m, 1n, 1o, 1p, 1q, 1r, 1s, 1t, 1u, 1v, 1w, 1x, 1y, 1z, 1aa, 1ab, 1ac, 1ad, 1ae, 1af, 1ag, 1ah, 1ai, 1aj, 1ak, 1al, 1am, 1an, 1ao, 1ap, 1aq, 1ar, 1as, 1au, 1av, 1aw, 1ax, 1ay, 1az, 1aa1, 1ab1, 1ac1, 1ad1, 1ae1, 1af1, 1ag1, 1ah1, 1ai1, 1aj1, 1ak1, 1al1, 1am1, 1an1, 1ao1, 1ap1, 1aq1, 1ar1, 1as1, 1au1, 1av1, 1aw1, 1ax1, 1ay1, 1az1, 1aa2, 1ab2, 1ac2, 1ad2, 1ae2, 1af2, 1ag2, 1ah2, 1ai2, 1aj2, 1ak2, 1al2, 1am2, 1an2, 1ao2, 1ap2, 1aq2, 1ar2, 1as2, 1au2, 1av2, 1aw2, 1ax2, 1ay2, 1az2, 1aa3, 1ab3, 1ac3, 1ad3, 1ae3, 1af3, 1ag3, 1ah3, 1ai3, 1aj3, 1ak3, 1al3, 1am3, 1an3, 1ao3, 1ap3, 1aq3, 1ar3, 1as3, 1au3, 1av3, 1aw3, 1ax3, 1ay3, 1az3, 1aa4, 1ab4, 1ac4, 1ad4, 1ae4, 1af4, 1ag4, 1ah4, 1ai4, 1aj4, 1ak4, 1al4, 1am4, 1an4, 1ao4, 1ap4, 1aq4, 1ar4, 1as4, 1au4, 1av4, 1aw4, 1ax4, 1ay4, 1az4, 1aa5, 1ab5, 1ac5, 1ad5, 1ae5, 1af5, 1ag5, 1ah5, 1ai5, 1aj5, 1ak5, 1al5, 1am5, 1an5, 1ao5, 1ap5, 1aq5, 1ar5, 1as5, 1au5, 1av5, 1aw5, 1ax5, 1ay5, 1az5, 1aa6, 1ab6, 1ac6, 1ad6, 1ae6, 1af6, 1ag6, 1ah6, 1ai6, 1aj6, 1ak6, 1al6, 1am6, 1an6, 1ao6, 1ap6, 1aq6, 1ar6, 1as6, 1au6, 1av6, 1aw6, 1ax6, 1ay6, 1az6, 1aa7, 1ab7, 1ac7, 1ad7, 1ae7, 1af7, 1ag7, 1ah7, 1ai7, 1aj7, 1ak7, 1al7, 1am7, 1an7, 1ao7, 1ap7, 1aq7, 1ar7, 1as7, 1au7, 1av7, 1aw7, 1ax7, 1ay7, 1az7, 1aa8, 1ab8, 1ac8, 1ad8, 1ae8, 1af8, 1ag8, 1ah8, 1ai8, 1aj8, 1ak8, 1al8, 1am8, 1an8, 1ao8, 1ap8, 1aq8, 1ar8, 1as8, 1au8, 1av8, 1aw8, 1ax8, 1ay8, 1az8, 1aa9, 1ab9, 1ac9, 1ad9, 1ae9, 1af9, 1ag9, 1ah9, 1ai9, 1aj9, 1ak9, 1al9, 1am9, 1an9, 1ao9, 1ap9, 1aq9, 1ar9, 1as9, 1au9, 1av9, 1aw9, 1ax9, 1ay9, 1az9, 1aa10, 1ab10, 1ac10, 1ad10, 1ae10, 1af10, 1ag10, 1ah10, 1ai10, 1aj10, 1ak10, 1al10, 1am10, 1an10, 1ao10, 1ap10, 1aq10, 1ar10, 1as10, 1au10, 1av10, 1aw10, 1ax10, 1ay10, 1az10, 1aa11, 1ab11, 1ac11, 1ad11, 1ae11, 1af11, 1ag11, 1ah11, 1ai11, 1aj11, 1ak11, 1al11, 1am11, 1an11, 1ao11, 1ap11, 1aq11, 1ar11, 1as11, 1au11, 1av11, 1aw11, 1ax11, 1ay11, 1az11, 1aa12, 1ab12, 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1ao63, 1ap63, 1aq63, 1ar63, 1as63, 1au63, 1av63, 1aw63, 1ax63, 1ay63, 1az63, 1aa64, 1ab64, 1ac64, 1ad64, 1ae64, 1af64, 1ag64, 1ah64, 1ai64, 1aj64, 1ak64, 1al64, 1am64, 1an64, 1ao64, 1ap64, 1aq64, 1ar64, 1as64, 1au64, 1av64, 1aw64, 1ax64, 1ay64, 1az64, 1aa65, 1ab65, 1ac65, 1ad65, 1ae65, 1af65, 1ag65, 1ah65, 1ai65, 1aj65, 1ak65, 1al65, 1am65, 1an65, 1ao65, 1ap65, 1aq65, 1ar65, 1as65, 1au65, 1av65, 1aw65, 1ax65, 1ay65, 1az65, 1aa66, 1ab66, 1ac66, 1ad66, 1ae66, 1af66, 1ag66, 1ah66, 1ai66, 1aj66, 1ak66, 1al66, 1am66, 1an66, 1ao66, 1ap66, 1aq66, 1ar66, 1as66, 1au66, 1av66, 1aw66, 1ax66, 1ay66, 1az66, 1aa67, 1ab67, 1ac67, 1ad67, 1ae67, 1af67, 1ag67, 1ah67, 1ai67, 1aj67, 1ak67, 1al67, 1am67, 1an67, 1ao67, 1ap67, 1aq67, 1ar67, 1as67, 1au67, 1av67, 1aw67, 1ax67, 1ay67, 1az67, 1aa68, 1ab68, 1ac68, 1ad68, 1ae68, 1af68, 1ag68, 1ah68, 1ai68, 1aj68, 1ak68, 1al68, 1am68, 1an68, 1ao68, 1ap68, 1aq68, 1ar68, 1as68, 1au68, 1av68, 1aw68, 1ax68, 1ay68, 1az68, 1aa69, 1ab69, 1ac69, 1ad69, 1ae69, 1af69, 1ag69, 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Items #18a-22a Film G548 10/8/80 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

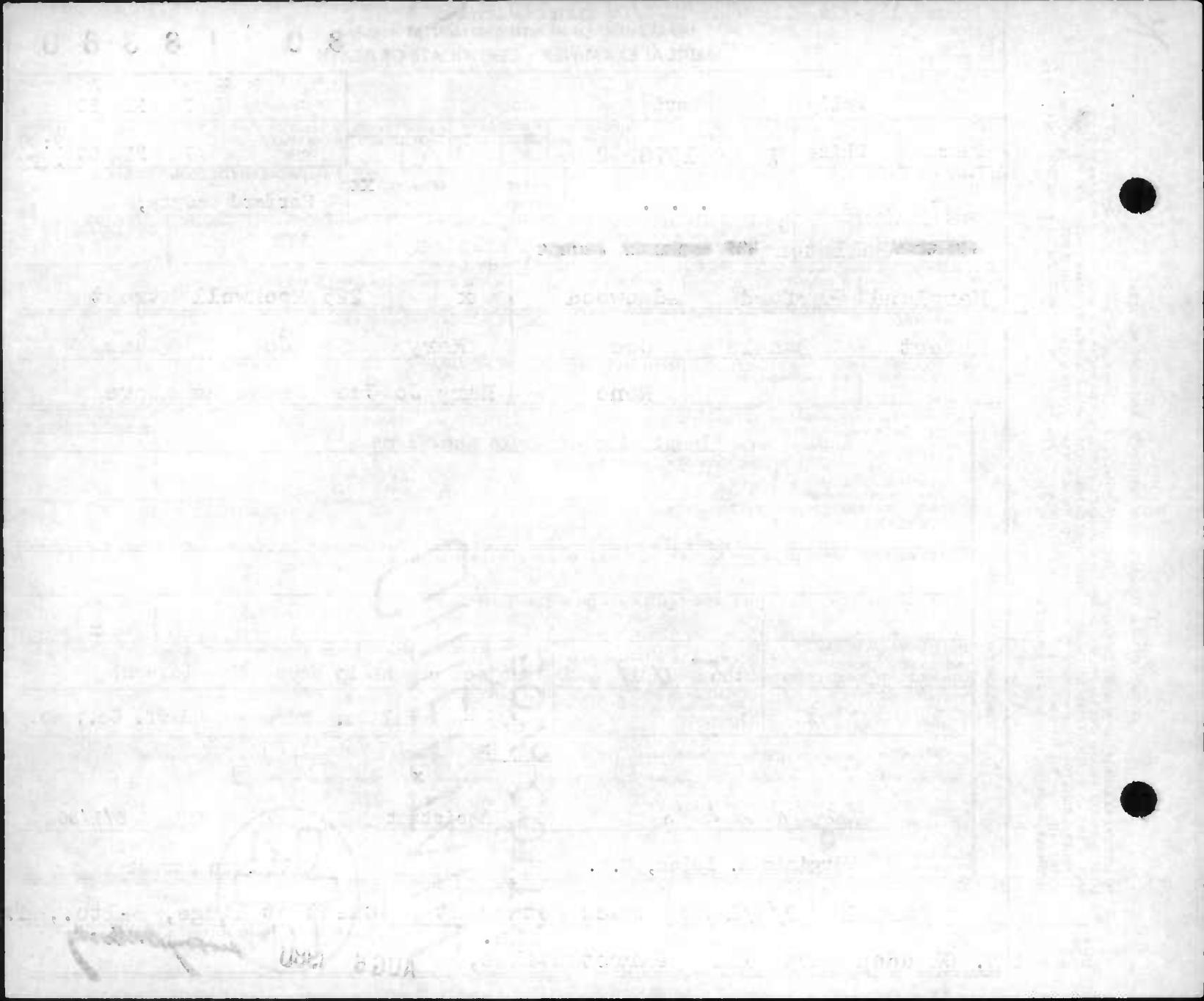
FOR  
 1- STATE  
 REGISTRAR

REG. NO. 8380

1. DECEASED NAME (TYPE OR PRINT)			FIRST Sally	MIDDLE Marie	LAST Coe	2a. DATE KNOWN OF DEATH ESTIMATED MATED	MONTH 7	DAY 31 <sub>19</sub>	YEAR 80	2b. HOUR M	
3. SEX Female	4. RACE White	S DATE OF BIRTH MONTH 7 DAY 24 YEAR 1978	6 AGE (IN YEARS LAST BIRTHDAY) 2 YRS.	IF UNDER 1 YR. MONTHS 0	IF UNDER 24 HRS. DAYS 0	2c. DATE PRONOUNCED DEAD	MONTH 7	DAY 31 <sub>19</sub>	YEAR 80	2d. HOUR PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED WIDOWED NEVER MARRIED DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH Harford County,			
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Edgewood		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 225 Rockwell Street			
14. FATHER'S NAME FIRST Robert		MIDDLE Donald		LAST Coe		15. MOTHER'S MAIDEN NAME FIRST Mary		MIDDLE Jo		LAST Wade	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Mary Jo Coe		ADDRESS same as above			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inhalation of Smoke and Flame</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> } (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR 6:46 M. MONTH 7/31 DAY 1980 YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject caught in house fire (arson)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home			21f. LOCATION STREET 225 Rockwell St. CITY OR TOWN Edgewood COUNTY Harf. Co., Md. STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Virginia L. Dolan</i>		TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER						
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.		ADDRESS 111 Penn Street			DATE SIGNED 8/1/80						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/4/1980		23c. NAME OF CEMETERY OR CREMATORIUM Grace Methodist			23d. LOCATION CITY OR TOWN Chestnut Ridge, Balto., Md.		COUNTY STATE		
24. FUNERAL DIRECTOR NAME M. Gladden Kurtz III		ADDRESS Jarrettsville,		Md.			25a. DATE REC'D. BY REGISTRAR AUG 6 1980		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR PERSONAL INFORMATION. PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M 7/77



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8018381
1 - FOR STATE REGISTRAR			REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Opal				Cook	7	26	80				3:54 P.M.	
3. SEX		4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White	MONTH	DAY	YEAR	70	YRS.	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
West Virginia		U.S.A.						Harford County				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Joppa, Md.		5409 Clayton Rd. 21085			Homemaker			Home				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			
Maryland		Harford		Joppa					3409 Clayton Rd. 21085			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
		George		Ferrell	Sonoma							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS				
no		233-84-6867			Mr. William H. Cook			Same as 13				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<p><i>Amputation of arm</i></p> <p>1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost</p> <p>{ (b) <i>Central vascular disease</i></p> <p>{ DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c) <i>Cerebral vascular disease</i></p>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>May 1980</i> , to <i>June 1980</i> , that (I) (we) last saw the deceased alive above, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.												
22b. SIGNATURE		22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED				
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS			<i>7900 Franklin St. May 2127</i>			7/30/80				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY	STATE		
Burial		7/30/80		Meadowridge			Dorsey		Howard	Md.		
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Duda-Ruck Inc.		7922 Wise Ave. 21222			JUL 30 1980			<i>Larry J. Brinkley</i>				

1608 1 18

1608 1 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8018382					
												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
Gladys			E	Courant		7-9-80						11:20PM					
3. SEX			4 RACE	5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
female			Caucasian	MONTH DAY YEAR			7d			MONTHS	YEARS	MONTHS	HOURS	MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
New Jersey			U.S.A.						Harford								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Havre de Grace			Citizens Nursing Home			ASSEMBLER			B.I.C. I.H.D.								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS								
Md			Harford			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			500 Mackoril Rd								
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME											
					Forb	FIRST UNKNOWN											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
No			161-63-4891			Family Records											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																	
(b) <i>cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF <i>Generalized arteriosclerosis</i>																	
(c) <i>old cerebrovascular accident</i> DUE TO, OR AS A CONSEQUENCE OF <i>old cerebrovascular accident</i>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Hyperthyroidism arteriosclerosis carotid vascular disease</i>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) this hospital attended the deceased from 8-21-79 to 7-9-80, that (I) (we) last saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22b. SIGNATURE					
												DEGREE			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS														
H. Evans & Son, Inc. 3185 Lewin Ave, Havre de Grace, MD 21078																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			23e. COUNTY STATE					
Burial			7-12-80			Fork Methodist			Fork								
24. FUNERAL DIRECTOR NAME			24a. FIRM'S NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Evans Funeral Chapel			8800 Hanover Rd			JUL 15 1980			John J. Murphy								

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100.00 m. 100.00 m.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80	18383		
												REG. NO.			
1 - STATE REGISTRAR			I. DECEASED NAME			LAST			2d. DATE OF DEATH			MONTH	DAY	YEAR	2d. HOUR
			William Donald Crawford Jr.						7/16/80						9:30 AM
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 12 HRS			
MALE		White		MONTH DAY YEAR			33			MONTHS	DAYS	HOURS	MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			BALTIMORE CITY OR COUNTY OF DEATH			MD.					
W. Va.		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Harford County								
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Fallston, Md.			Fallston General Hospital			Foreman			Flooring						
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS					
Maryland			Harford		Bel Air					2237 Thomas Run Road					
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME			MIDDLE						
William Donald			Crawford			Elizabeth Margaret Koncer			LAST						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
			220-48-5206			William D. Crawford, Sr., Bel Air, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
2028 Cardio-pulmonary failure															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															
(b) Large cell lymphoma of lung															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
19b.									YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 21)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive an above, (I) (we) (did) (did not) view the body after death			22b. SIGNATURE EV Platia			22c. DATE SIGNED 7/16/80									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EV Platia			22e. ADDRESS Fallston Gen Hosp												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE July 19, 1980			23c. NAME OF CEMETERY OR CREMATORIAL BelAir Mem. Gardens			23d. LOCATION CITY OR TOWN Bel Air			COUNTY Harford	STATE Md.		
24 FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md.			25a. DATE REC'D. BY REGISTRAR JUL 18 1980			25b. REGISTRAR'S SIGNATURE Howard McComas									
ADDRESS															

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.



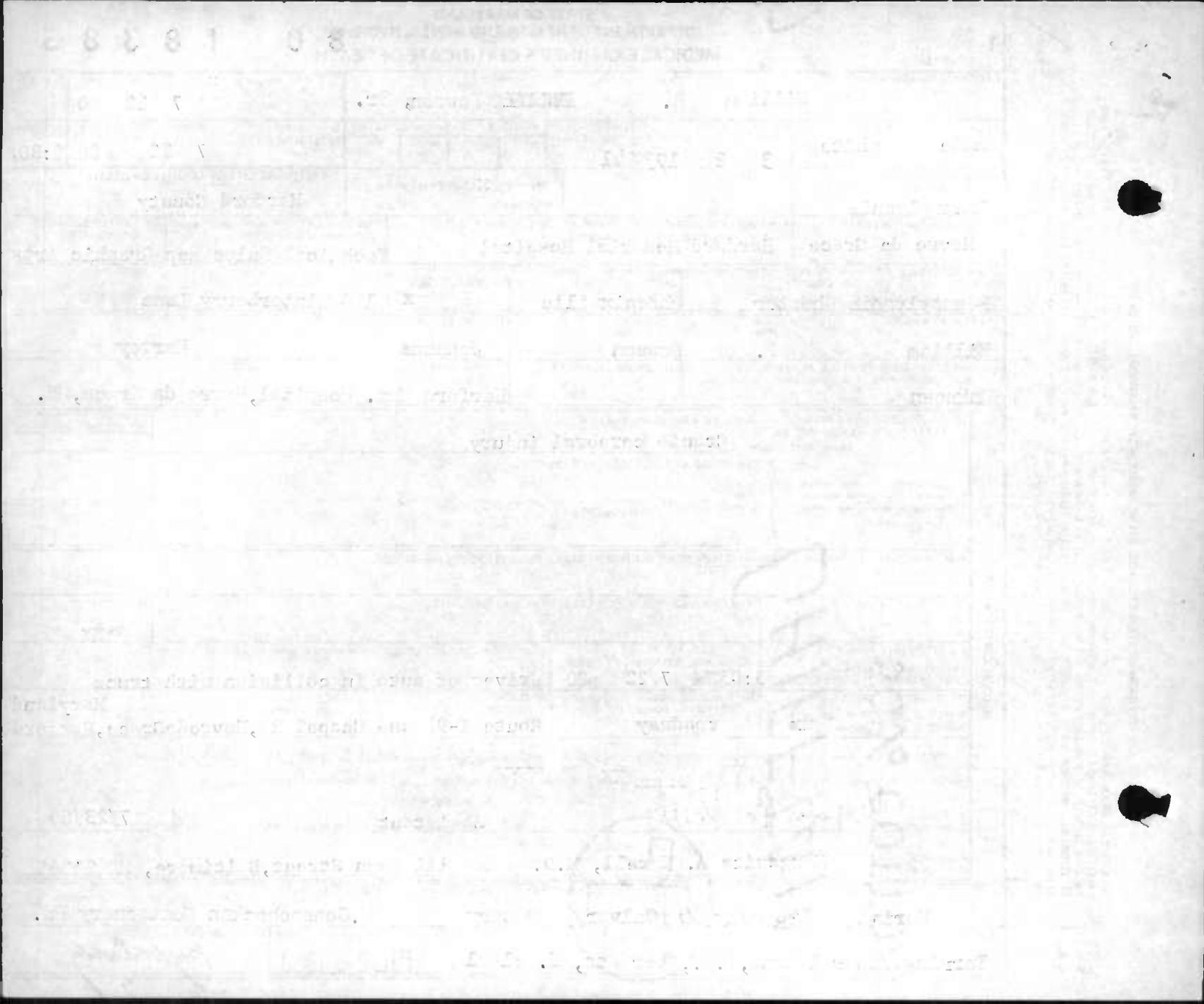
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8018384				
												REG. NO.				
1 - STATE REGISTRAR																
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
Gloria Judy Davis						July 10, 1980						3:41 AM				
3. SEX			RACE	S. DATE OF BIRTH			MONTH	DAY	YEAR	6 AGE (IN YEARS LAST BIRTHDAY)						
Female			White	11 9 1929						50	YRS.	IF UNDER 1 YEAR	IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			NEVER MARRIED	<input type="checkbox"/>	WIDOWED	DIVORCED	MONTHS	DAYS	HOURS	MIN.
New York			USA			<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
HARFORD de Grace			HARFORD Memorial Hosp.			Homemaker			Home							
13a. STATE			13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS						
Md.			HARFORD	Aberdeen			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			646 Law St.						
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST					
Robert				Traina		Florence					Traina					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
No			110-22-8350			Kenneth M. Davis, 646 Law St., Aberdeen, Md.										
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a) <i>Ca of st parathyroid gland</i>																
DUE TO, OR AS A CONSEQUENCE OF (b) <i>o widespread metastasis</i>																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
19b.						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <i>April 80</i>			CITY OR TOWN <i>210 80</i>	COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>7/10/80</i> to <i>7/10/80</i> , that (I) (we) last saw the deceased alive on <i>7/10/80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>blued jin</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>7/10/80</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Judy Davis</i>			22e. ADDRESS <i>Harm de Grace, Md.</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12 July 1980			23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Mem. Gardens			23d. LOCATION CITY OR TOWN <i>Bel Air</i>			COUNTY <i>Harford</i>	STATE <i>Maryland</i>			
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, Md. 21001			ADDRESS			25a. DATE REC'D. BY REGISTRAR JUL 15 1980			25b. REGISTRAR'S SIGNATURE <i>John Murphy</i>							

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH8018385  
REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, BASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.  
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR			
				William	R.	Dawson	<input checked="" type="checkbox"/>	7	22	1980	M			
3 SEX male	4 RACE white	5. DATE OF BIRTH MONTH 3	DAY 2	YEAR 1939	6. AGE (IN YEARS LAST BIRTHDAY) YRS. 41	IF UNDER 1 YR. MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN. 0	2d. HOUR				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania				7b. CITIZEN OF WHAT COUNTRY? USA				7c. DATE PRONOUNCED DEAD 7 22 1980			2d. HOUR 6:30 P.M.			
10. CITY OR TOWN OF DEATH Havre de Grace				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Technical Sales Rep			12b. KIND OF BUSINESS OR INDUSTRY Graphic Arts			
13a. STATE Pennsylvania				13b. COUNTY Chester				13c. CITY OR TOWN Phoenixville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 110 Winterberry Lane		
14. FATHER'S NAME FIRST William				MIDDLE P.				LAST Dawson			15. MOTHER'S MAIDEN NAME FIRST Johanna	MIDDLE	LAST Harvey	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Unknown				16b. SOCIAL SECURITY NO.				17. INFORMANT			ADDRESS Harford Mem. Hospital, Havre de Grace, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cranio cerebral injury</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
7 8/20 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5:05 PM 7/22 1980				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) <b>driver of auto in collision with truck</b>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway				21f. LOCATION STREET Route I-95 and Chapel Rd, Havre de Grace, Harford CITY OR TOWN COUNTY Maryland						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE <i>Margarita Korell</i>														
EXAMINER'S NAME (TYPE OR PRINT)				MARGARITA A. KORELL, M.D.				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 7/23/80		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE Burial 26 July 80				23c. NAME OF CEMETERY OR CREMATORIAL Calvary Cemetery				23d. LOCATION CITY OR TOWN W. Conshohocken	COUNTY Montgomery	STATE Pa.
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, Md. 21001								25a. DATE REC'D. BY REGISTRAR JUL 29 1980				25b. REGISTRAR'S SIGNATURE <i>Larry McReady</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8018386					
1 - STATE REGISTRAR			REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Florence Walton Deitz												July 19 1980					7:00 A.M.
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female			white			MONTH DAY YEAR			90			MONTHS DAYS		HOURS MIN			
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Maryland			U.S.A						Harford								
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Harve de Grace			Duncon's Private Home Care			None			None			3100 HARFORD ROAD					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		13f. ADDRESS			
Maryland			Harford			Hydes						230 Hydes, Md. 21087		Kingsville			
14. FATHER'S NAME			FIRST MIDDLE LAST			15 MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES			16b. SOCIAL SECURITY NO		17 INFORMANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
William Henry Walton						Florence Williametta Galloway Fuller Walton			No			213-74-0195		Eleanor D. Gebler - 7103 Sunshine Ave, Md 21087 daughter		24 hrs	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b)			DUE TO, OR AS A CONSEQUENCE OF (c)								
4289						Heart Failure											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						old age											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a I certify that (I) this hospital attended the deceased from 6/12 1980 to 7/19 1980, that (I) (we) last saw the deceased alive on above (I) (we) did (I did not) view the body after death.																	
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED								
Phyllis K. Pullen			MD									7/19/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			2807 Jerusalem Rd, Kingsville, Md. 21087											
Burial			23b. DATE 7-22-1980			23c. NAME OF CEMETERY OR CREMATORIAL St. John's Epis. Ch. Cem.			23d. LOCATION CITY OR TOWN Kingsville			COUNTY Balto.		STATE Md.			
24 FUNERAL DIRECTOR NAME E.F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087			ADDRESS			25a. DATE REGD. JUL 28 1980			25b. TYPE OF REGISTRATION REGISTRATION			25c. REGISTRATION NO.					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8018387								
											REG. NO.									
1. FOR STATE REGISTRAR			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR								
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	7-3-80						2:15 P.M.								
Edward EARL DUFF																				
3. SEX			4 RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN								
Male			White	3-13-1904			76													
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. COUNTRY OF WHOM COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.								
Md.			U.S.A.						HARFORD											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
HARFORD			HARFORD MEMORIAL HOSPITAL			Labor			CIVIL SER.											
13a. STATE			13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS										
Md.			CECIL	PORT DEPOSIT						51 HIGH ST										
14. FATHER'S NAME FIRST			MIDDLE	15. MOTHER'S MAIDEN NAME FIRST			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
Thomas				Naomi			216-09-5061			Marvin Duff			132 Five Tower Rd. Port Deposit Md.							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			16c. IMMEDIATE CAUSE (a)			16d. DUE TO, OR AS A CONSEQUENCE OF (b)			16e. DUE TO, OR AS A CONSEQUENCE OF (c)								
Yes			2 days			Cerebral vascular accident			Atherosclerotic cardiovascular disease											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE							
22a. I certify that (I) (this hospital) attended the deceased from 7-1-80 to 7-3-80, that (I) (we) last saw the deceased alive on 7-3-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.																				
22b. SIGNATURE			DEGREE			22c. DATE SIGNED														
R.L. SITAROSS			Mrs			7/3/80														
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		
RICHARD L. GOODIE			McMILLION F.H.			1870 Belair Rd Fallside Ed 21047			7-5-80			Hopewell Cem. Port Deposit			Cecil Md.					
24. FUNERAL DIRECTOR NAME			ADVISER			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
Richard L. Goodie			Krisen Sun, Md.			JUL 9 1980			HARRY McELROY											

1884-08

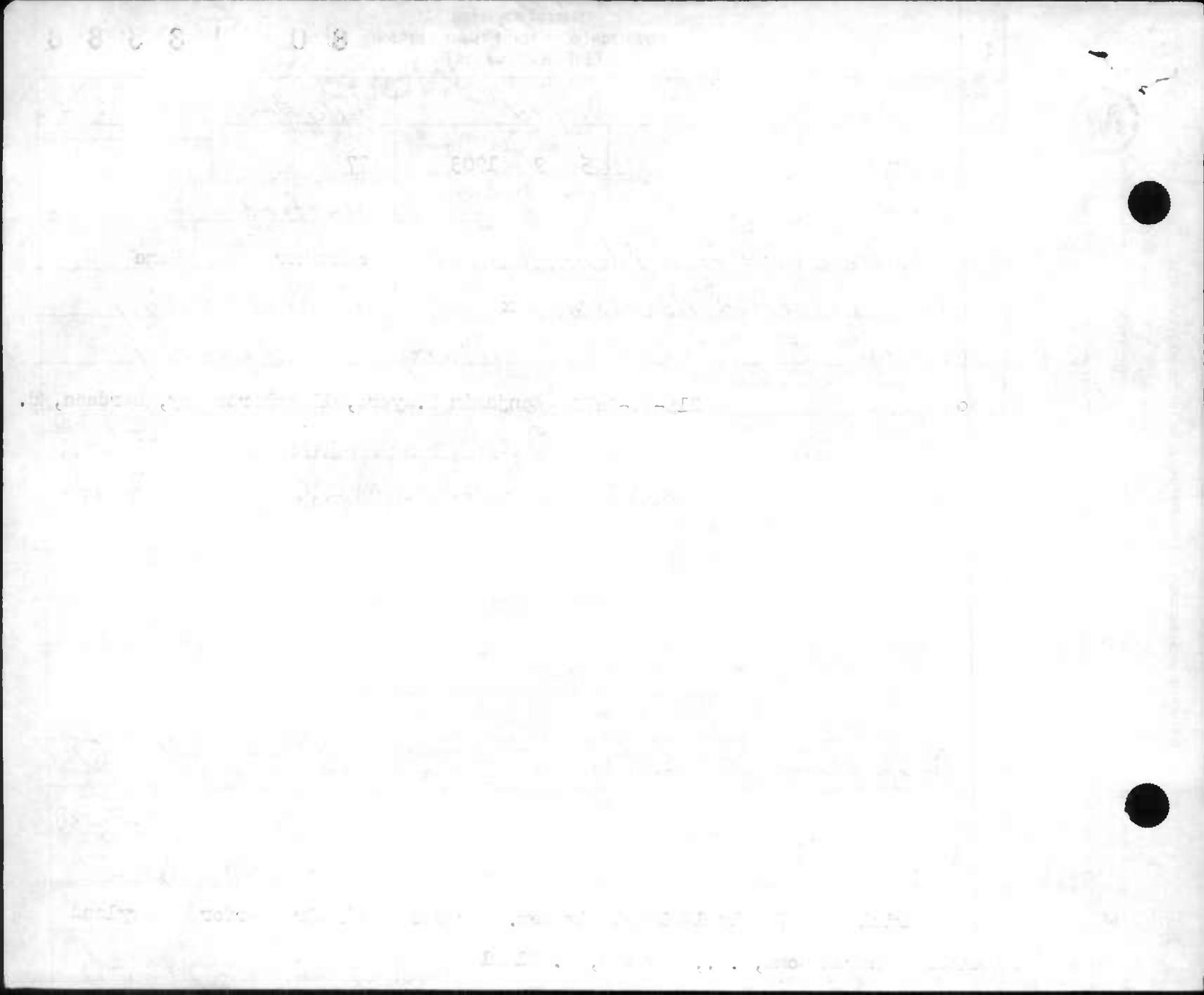
102.134.3 102.134.3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 0	1 8 3 8 8					
												REG. NO.						
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR						
			Bertha B. DUGAN						July 3rd, 1980			12 A M						
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY) YRS			7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		8 IF UNDER 24 HRS MONTHS DAYS HOURS MIN						
Female		White		5 9 1903			77											
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Harford			10 CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hartford Mem Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Home	
13a STATE Md		13b COUNTY Harford		13c CITY OR TOWN Aberdeen			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS 411 Roberts Way			14 FATHER'S NAME William S. Byers		15 MOTHER'S MAIDEN NAME Mary Heverly			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 215-18-0170		17 INFORMANT Benjamin H. Byers, 411 Roberts Way, Aberdeen, Md.			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4409 Diseases of the heart and lungs			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) Generalized Arteriosclerosis			(c)											5 yr.		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE												
22. I certify that (I) (this hospital) attended the deceased from <u>7-3-80</u> to <u>7-3-80</u> , that (I) (we) last saw the deceased alive on <u>7-3-80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated																		
23. SIGNATURE _____ DEGREE _____																		
24. PHYSICIAN'S NAME (TYPE OR PRINT) Peter P. Pachman, M.D.			22a ADDRESS 8 Law St., Aberdeen, Md.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7-3-80									
23b. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23c. DATE 7 July 1980			23d. NAME OF CEMETERY OR CREMATORIAL Bel Air Mem. Gardens			23d. LOCATION CITY OR TOWN Bel Air COUNTY Harford STATE Maryland									
24 FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, Md. 21001			25a. ADDRESS Tarring Funeral Home, P.A., Aberdeen, Md. 21001			25b. DATE REC'D. BY REGISTRAR JUL 10 1980			25b. REGISTRAR'S SIGNATURE H. J. Murphy, Jr.									



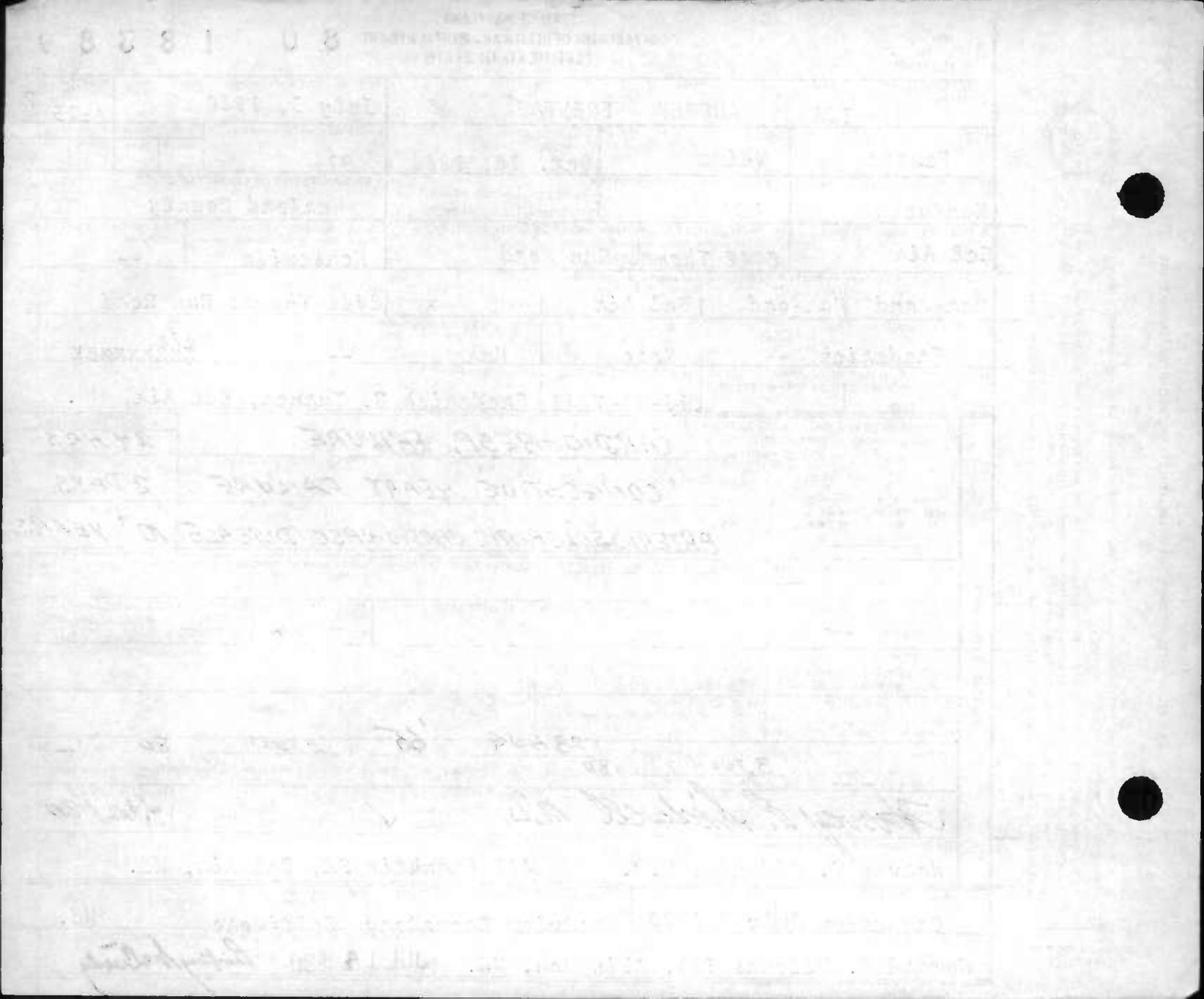
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medicorexaminer must be notified at once.

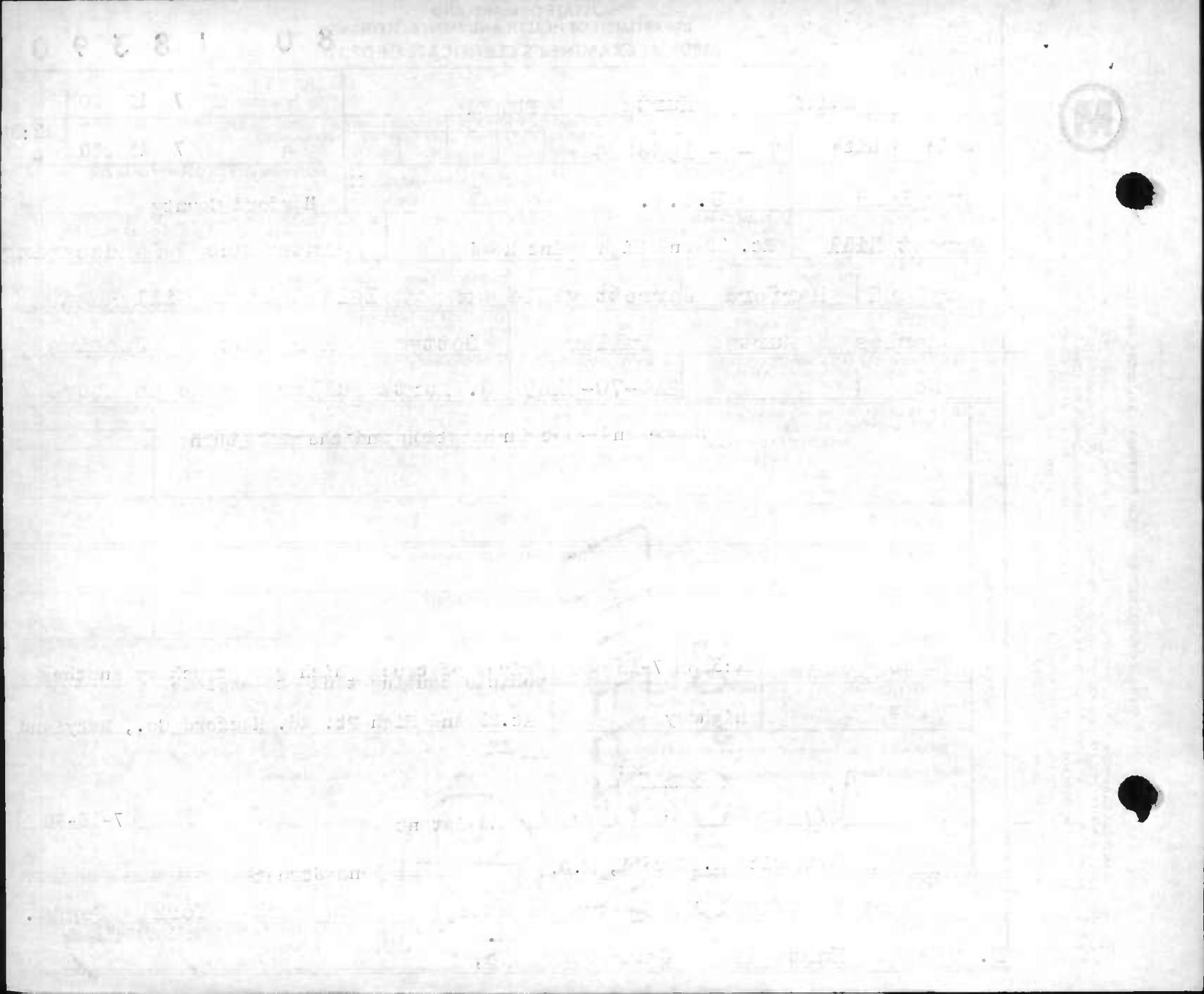
## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80118389				
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
IDA AUDREY FREYTAG						July 3, 1980						6:15 P				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.				
Female		White		Oct. 10, 1888			91									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Kentucky		USA					Harford County									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Bel Air		2442 Thomas Run Road			Housewife			--								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS						
Maryland		Harford		Bel Air						2442 Thomas Run Road						
14. FATHER'S NAME FIRST		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			Reis LAST					
Frederick		--		Rose	Mary			--			KANNANAK					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
no		218-03-7742			Frederick G. Turner, Bel Air, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
4/22 CARDIO-RESP. FAILURE												24 HRS				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF CONGESTIVE HEART FAILURE												2 DAYS				
(c) DUE TO, OR AS A CONSEQUENCE OF ARTERIOSCLEROTIC CARDIO-VASC. DISEASE												10+ YEARS				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
19					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from 23 AUG 66, 19 80, to 31 OCT 19 80, that (I) (we) last saw the deceased alive on 3 JULY 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.																
22b. SIGNATURE Harvey P. Sidwell M.D.		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED JULY 80								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			401 Franklin St, Bel Air, Md.											
Harvey P. Sidwell, M.D.																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE				
Cremation July 1, 1980				Westview Crematory			Baltimore									
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Howard K. McComas III, Abingdon, Md.					JUL 14 1980						Harry McComas					
DHMH-1650M7/77 (VRA 15 (4))																



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS OF DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 18390
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED			MONTH	DAY	YEAR	2b. HOUR
BARRY			Kurtz	FULLER		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7	15	1980	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR 24 HOUR 12:30 P.M.
male	white	7 - 2 - 1956	24			<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	7	15	1980	P.M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland			U.S.A.			<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Harford County			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Forest Hill			Rt. 23 and High Point Road			Maintenance			Landscaping			
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS
Maryland			Harford			Jarrettsville						1216 Baldwin Mill Road
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			LAST			
Charles			Kurtz			Betty			Margaret			Jenkins
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
No			214-70-9169			C. Kurtz Fuller			same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Thermal Burns												*APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Smoke-and-soot-inhalation and thermal burns												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												
(b) DUE TO, OR AS A CONSEQUENCE OF												
(c) _____												
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
						<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 11:30 AM 7-15 1980			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) highway			driver of truck which was struck by another vehicle causing tank to explode						
22a. I certify that I took charge of the remains described above, held an			Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			TITLE (SPECIFY)						
death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/>						M.D. Assistant						
ACTUAL SIGNATURE Margarita Korell						MEDICAL EXAMINER						
EXAMINER'S NAME (TYPE OR PRINT)			Margarita A. Korell, M.D.			ADDRESS			111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORI			23d. LOCATION CITY OR TOWN			
Burial			7/18/1980			Centre Cemetery			New Park			
24. FUNERAL DIRECTOR NAME			ADDRESS			Md.			COUNTY			
M. Gladden Kurtz III			Jarrettsville,						York			
25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
JUL 16 1980			Gladden									
DHMH - 17 (VR A15 ME (5)) 15M7/77												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please \_\_\_\_\_ be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 18391
												REG. NO.
1 - STATE REGISTRAR						2a DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	July 14, 1980			7	21	80	11 AM
2. SEX			4 RACE	5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		
Male			White	July 14, 1913					67	IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.
Baltimore, Maryland			U.S.A.						Harford Co., MD.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Fallston			Fallston General Hospital.			MAINTENANCE WORKER			Sugar Refinery			
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			
Maryland			Harford Co.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			1200 Bonaire Road			
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST	
Michael					Griffin	Catherine					Zimmerman	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT(S) 557-7711			ADDRESS			
NO			216-07-2959			Mr. Paul M. Griffin, Jr.			3613 Advocate Hill Drive JANETTEVILLE, Maryland 21084			
18. CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and 1(c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Lanidoc Anest</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7th</u>												
4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO, OR AS A CONSEQUENCE OF Severe C.R.D. } (c) DUE TO, OR AS A CONSEQUENCE OF A.C.V.D.												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7-21-80</u> , to <u>7-21-80</u> , that (I) (we) lost sow the deceased alive on <u>7-21-80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Dr. Michael J. Bain</u>			22c. DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>7/21/80</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. Michael J. Bain</u>			22e. ADDRESS <u>1716 Harford Road - Fallston, MD 21047</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>July 24, 1980</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>St. Ignatius Cath. Ch. Cemetery</u>			23d. LOCATION CITY OR TOWN <u>Forest Hill, Harford Co., Maryland 21050</u>			
24. FUNERAL DIRECTOR <u>Joseph William Foster</u>			24b. ADDRESS <u>W. Broadway &amp; Williams St., Bel Air, Maryland 21014</u>			25a. DATE REC'D. BY REGISTRAR <u>JUL 24 1980</u>			25b. REGISTRATION NO. <u>Secretary</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial/tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80	18392				
												REG. NO.					
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			2a DATE OF DEATH			2b. MONTH			2c. DAY		2d. YEAR		2e. HOUR	
			<i>Samuel Camarata Guercio</i>			DEC 21, 1980			7-19-80			35		6 PM		35	
1. SEX			4 RACE			5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY) YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			Harford Co.		MD.			
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY								
Fallston			Fallston General Hospital			BARBER			Barber Shop								
13a STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS					
Maryland			Harford Co.			Bel Air						1808 Bel Air Road					
14 FATHER'S NAME			MIDDLE			15. MOTHER'S MAIDEN NAME			LAST								
Salvatore			—			Carmela			—			Camarata					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT(SO) 4-465-5074 ADDRESS						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No			213-36-8330			Mr. John P. Guercio			2926 Southview Road			Ellisott City, Maryland 21043					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a)			CAR DIAC arrest → Acute MI						-1 day					
410			DUE TO, OR AS A CONSEQUENCE OF (b)			Stroke C.A.D						years					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			DUE TO, OR AS A CONSEQUENCE OF (c)			Atherosclerosis						years					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
C.O.P.D.																	
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21e INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21f PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21g LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a I certify that (i) this hospital attended the deceased from <u>6/28</u> to <u>7/12</u> 19 <u>79</u> , that (ii) we last saw the deceased alive on <u>7/12</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (ii) (we) (did) not view the body after death.																	
22b SIGNATURE <i>Mur</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED July 19, 1980								
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>V.S. NAIR M.D.</i>			22e ADDRESS <i>1716 Mayfield Road - Elkridge 21047</i>														
23e BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23f DATE <i>July 22, 1980</i>			23g NAME OF CEMETERY OR CREMATORIUM <i>St. Ignatius Cath. Ch. Cemetery</i>			23h LOCATION CITY OR TOWN <i>Forest Hill Harford Co., Maryland 21050</i>			COUNTY STATE					
24 FUNERAL DIRECTOR <i>Joseph William Foster</i>			ADDRESS <i>W. Broadway &amp; Williams St. Bel Air, Maryland 21014</i>			25e DATE REC'D. BY REGISTRAR <i>JUL 22 1980</i>			25f REGISTRAR'S SIGNATURE <i>John J. Murphy</i>								

5 8 8 1 . 0 8

(M)

22-41-8

CEMETERY

100 feet from white oak

30 feet

white

white

soil dark brown with

leaves #351 x - + miles south from

straw - leaves dried - white

soil brown brownish brown

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please do not retain by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8018393		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
<i>Claude William Haire</i>						<i>July 14 1980</i>			<i>3:18 AM</i>					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS-NOT BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS			2b. HOUR IF UNDER 24 HRS HOURS MIN.				
<i>Male</i>		<i>White</i>		<i>5-10-1912</i>			<i>68</i>							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			7c. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i>			MD.				
8a. CITY OR TOWN OF DEATH <i>Havre de Grace</i>		8b. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Hartford Mem. Hospital</i>		8c. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <i>Plumber Pt Set Engr.</i>			8d. KIND OF BUSINESS OR INDUSTRY <i>Plumber Pt Set Engr.</i>							
9a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <i>Md Cecil</i>		9b. COUNTY <i>Cecil</i>		9c. CITY OR TOWN <i>Rising Sun</i>			9d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			9e. STREET ADDRESS <i>549 Rising Sun Rd.</i>				
10. FATHER'S NAME FIRST		MIDDLE		11. MOTHER'S MAIDEN NAME FIRST			12. ADDRESS <i>Houck</i>							
<i>Albert</i>				<i>Laura</i>										
13a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		13b. SOCIAL SECURITY NO		13c. INFORMANT			13d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
<i>No</i>		<i>216-18-2498</i>		<i>Mrs Claude Haire (Same)</i>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)														
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary artery dis. As CVD</i>														
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hyp. Drenes</i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>7-14 1980</i> , to <i>7-14 1980</i> , that (I) (we) last saw the deceased alive on <i>7-14 1980</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>C. H. Calow</i>		22c. DEGREE <i>M.D.</i>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>7-14-80</i>							
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <i>A. H. CALOW</i>		22g. ADDRESS <i>60 S. Union Ave. Harryd Gr.</i>												
23a. BURIAL, CREMATION, REMOVAL (TYPE) <i>Burial</i>		23b. DATE <i>7-16-80</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Brookview</i>			23d. LOCATION CITY OR TOWN <i>Rising Sun Cecil Md.</i>			23e. COUNTY STATE <i>Md.</i>				
24. FUNERAL DIRECTOR <i>J. Muller</i>		25a. ADDRESS <i>Rising Sun Md.</i>		25b. DATE REC'D. BY REGISTRAR <i>JULY 17 1980</i>			25c. REGISTRAR'S SIGNATURE <i>Victor McCreedy</i>							



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH FORM PM, IN THE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 8018394
1. DECEASED NAME (TYPE OR PRINT)			FIRST RONALD	MIDDLE EUGENE	LAST HALL	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH 7	DAY 19	YEAR 80	2b. HOUR 12 M
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) May 8 1956 24 yrs.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD			MONTH 7	DAY 19	YEAR 80	2d. HOUR 24 M 7:30 a.m.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County						
10. CITY OR TOWN OF DEATH Churchville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carson Run Rd. so. Stephney Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter			12b. KIND OF BUSINESS OR INDUSTRY construc.			
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2512 Carsins Run Road				
14. FATHER'S NAME FIRST William		MIDDLE Sylvester	LAST Hall	15. MOTHER'S MAIDEN NAME Helen Louise		16. SOCIAL SECURITY NO. 2116-66-8878		17. INFORMANT Mrs. Louise Gullion, Edgewood, Md.				
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		18b. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		18c. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Multiple injuries 8147		18d. IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		18e. IMMEDIATE CAUSE (b) DUE TO, OR AS A CONSEQUENCE OF		18f. IMMEDIATE CAUSE (c) DUE TO, OR AS A CONSEQUENCE OF		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		19c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:03 PM 7-19-1980		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) Subject lying in roadway & was run over by auto								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET Carson Run Rd. so. Churchville, Harford CITY OR TOWN COUNTY STATE Stephney Rd. Md.								
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE <i>Ann M. Dixon</i>		EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER		DATE SIGNED 7-19-80						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 23, 1980		23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Mem. Gardens		23d. LOCATION CITY OR TOWN Bel Air Harford Md.						
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md.		25a. ADDRESS 111 Penn St.		25b. DATE REC'D. BY REGISTRAR JUL 23 1980		25c. REGISTRAR'S SIGNATURE <i>John J. Murphy</i>						

9561 U.S.

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Item 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8018395		
										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH MONTH DAY YEAR			2b HOUR			
<i>Bertha Louise Harkins</i>					Harkins	July 9, 1980			1:45 P.M.			
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS			2b HOUR IF UNDER 24 HRS HOURS MIN		
Female		White		March 29, 1894			86 YRS.			1:45 P.M.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Maryland		U.S.A.					Harford County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Forest Hill		2235 Ady Road								Housewife		
13a. STATE Maryland		13b. COUNTY Harford Co.		13c. CITY OR TOWN Forest Hill			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2622 Ady Road		12b. KIND OF BUSINESS OR INDUSTRY Homemaker	
14. FATHER'S NAME FIRST: Thomas MIDDLE: Archer LAST: Monks		15. MOTHER'S MAIDEN NAME FIRST: Mary MIDDLE: N. LAST: Phillips										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-54-0113		17. INFORMANT (SW) 838-3827, ADDRESS Mr. Addison N. Harkins Forest Hill Maryland 21050			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <i>2500</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		27 years  DUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes mellitus</i>								30 years?  17 years.		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  <b>Low pressure hydrocephalus</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from July 13, 1948, to July 9, 1980, that (I) (we) last saw the deceased alive on July 7, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Robert Barthel</i>		22c. DEGREE M.D.		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED July 9/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert A. Barthel, M.D.</i>		22e. ADDRESS 2501 Rocks Road, Forest Hill, Maryland 21050										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 11, 1980		23c. NAME OF CEMETERY OR CREMATORIAL DEER CREEK Meth. Ch. Cem.			23d. LOCATION CITY OR TOWN Forest Hill, Harf. Co., Maryland 21050		COUNTRY STATE			
24. FUNERAL DIRECTOR <i>Joseph William Foster</i>		ADDRESS W. Broadway & Williams Sts. Bel Air, Maryland 21014		25a. DATE REC'D. BY REGISTRAR JUL 15 1980			25b. REGISTRAR'S SIGNATURE <i>John J. Kennedy</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80	18396				
										REG. NO.					
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			LAST			2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
			NANNIE BELLE HAYTON						9-12-80						A 7:40
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female			White			MONTH DAY YEAR			85			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Virginia			U.S.A.						HARFORD			BALTIMORE CITY OR COUNTY OF DEATH			
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
HAURE DE GRACE			HARFORD MEMORIAL HOSPITAL			Housewife			R.H. Own Home						
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			
Md			CECIL			Conowingo						21 WEAVERS MEADOWS RD.			
14 FATHER'S NAME			FIRST	MIDDLE	LAST	15 MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST				
UNK.			UNK.	UNK.	UNK.	UNK.			UNK.	UNK.	UNK.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No			-			m Henrey Meadows			Same as above						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a))										shock					
586-										DUE TO, OR AS A CONSEQUENCE OF (b) Arteria					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										DUE TO, OR AS A CONSEQUENCE OF (c) Acute Renal Failure					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										Pneumonia					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from 6-18-80 to 7-12-80, that (I) (we) lost saw the deceased alive on 7-12-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			DANTE MONAKIC			622 S. Union Ave. Harford Cr. Md			7/12/80						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE		
Burial			7-15-80			Red Oak Cem.			Ceres			Baltimore	Md.		
24 FUNERAL DIRECTOR NAME			ADDRESS			MC MACHEN, E. J. II			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Richard L. Goodie			Racing Sun, Md.			JUL 15 1980						L. Goodie			

08281 08

22 May 2008

Wetland area

near north branch of stream

Small tree sapling tree 1m tall  
20 cm dbh. Subtropical species  
→ 100+

Young sand tree 1m tall  
10 cm dbh. Subtropical species

Young sand tree 1m tall  
10 cm dbh. Subtropical species

Young sand tree 1m tall  
10 cm dbh. Subtropical species

Young sand tree 1m tall  
10 cm dbh. Subtropical species

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8018397				
												REG. NO.				
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			MIDDLE SHANER			LAST			2d. DATE OF DEATH MONTH DAY YEAR			2d. HOUR	
FRANCES Shaner			SHANER			HUFF			07 29 80			8:05 P.M.				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
F		White		07 04 09			41			MONTHS DAYS		HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH									
Virginia		USA					Harford County									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY									
FALLSTON		FALLSTON GENERAL Hosp.					Owner-Opr. Restaurant									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			MD.			
Maryland		Harford		Bel Air						240 Crocker Drive						
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST			16. SOCIAL SECURITY NO			17. INFORMANT ADDRESS						
George		Bert		Kate			226-01-0133			Mrs. Edward Westing, Bel Air, Md.						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)			19. DUE TO, OR AS A CONSEQUENCE OF (b) 2. CARCINOMA of rt lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
no				1. Perforation of bowel due to metastatic CANCER												
16c. DUE TO, OR AS A CONSEQUENCE OF (c)		With metastasis to bone & abdominal viscera														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Renal Failure and Anemia Secondary due to CARCINOMA.																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/29/1980 to 7/30/1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE D. L. Pirovolidis		22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 7/30/80									
22e. PHYSICIAN'S NAME (TYPE OR PRINT) D. L. Pirovolidis		22f. ADDRESS 1716 HARFORD Rd FALLSTON, Md.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE July 29, 1980		23c. NAME OF CEMETERY OR CREMATORY John M. Oakeys & Son Salem			23d. LOCATION CITY OR TOWN			23e. COUNTY Roanoke						
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md.		25a. ADDRESS 1047 Main Street, Roanoke, Va.		25b. DATE REC'D. BY REGISTRAR JUL 31 1980												
BP _____																
DHMH-16 25M (VRA 15, 4) 1/79																

1968 1 0 3

AMIA) location of sub. I and/or antecedent

and II for AMIA and  
unpublished figures & evidence in Hovey

AMIA) of sub. primary enough to a certain level

AMIA) of sub. primary enough to a certain level

AMIA) of sub. primary enough to a certain level

AMIA) of sub. primary enough to a certain level

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8018398				
										REG. NO.				
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		July 30 1980		2 P.M.			
Anthony Justin Hyde JR.														
3. SEX			RACE		4. DATE OF BIRTH MONTH DAY YEAR		5. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.							
Male			White		July 7, 1930		50 YRS.							
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford							
Penns			USA				MD.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Havre de Grace			Harford Memorial Hosp							Art Director			U.S.Govt.	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Md			Harford		Bel Air				117 Churchville Rd.					
14. FATHER'S NAME			FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME					
Anthony Justin Hyde SR.									Betty Elizabeth					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT (Wife) 838-3552 ADDRESS							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Yes			1849-1950		Mrs. Jo Devere Hyde 117 Churchville Road Bel Air, Maryland 21014									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY			Nasopharyngeal Carcinoma With Intracranial Invasion.											
IMMEDIATE CAUSE (a)														
1479														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last														
(b)														
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7-24, 1980, to 7-30, 1980, that (I) (we) lost the deceased alive on 7-30, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.														
22b. SIGNATURE			DEGREE							ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
Sang W. Kim			M.D.									7/30/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS											
Sang W. Kim			801 S. Union Ave. Havre de Grace,											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial			August 1, 1980		Bel Air Memorial Gardens		Bel Air, Harford Co., Maryland		21014		Md.			
24. FUNERAL DIRECTOR Joseph William Foster			ADDRESS							25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
			W. Broadway & Williams St. Bel Air, Maryland 21014							AUG 04 1980		Joseph McReady		

8 0 0 8 1 0 0

- 93

Edward T. A.

### Handwriting

111 CAMPBELL'S ROAD  
MELBOURNE 3000  
(03) 622-3222

27

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8018399		
												REG. NO.		
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
EVAN LEROY JOB									7-11-80			10 49 M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
Male		White		10-4-1900			79							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Md.		U.S.A.					HARFORD							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Harford		Harford Memorial Hospital			Farmer Ret			Own Farm.						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		Sunrise Dr.				
Md		CECIL		Rising Sun				NOTTINGHAM VIEW - Box 29						
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			ADDRESS			Brown				
Haines		— Job		Carrie			Same as Deceased (wife)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No		215-24-6254			Mrs. Evan Job			Cardio pulmonary arrest						
								Due to, or as a consequence of: (b) Acute Antrosoepal myocardial dysrhythmia						
								(c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7-4 1980 to 7-11 1980, that (I) (we) last saw the deceased alive on 7-11 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Leticia S. Galway M.D.					DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7-11-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 7-13-80			23c. NAME OF CEMETERY OR CREMATORIAL TENNE (F.H.)			23d. LOCATION CITY OR TOWN Calvert County Cecil Md						
Burial					Rose Bank Cem.									
24. FUNERAL DIRECTOR NAME		ADD.			25a. DATE REC'D. BY REGISTRAR APR 15 1980			25b. REGISTRAR'S SIGNATURE Anthony McElroy						
Richard L. Goodie														

1968 1 08

1968-1-2 356 2431 4673

1968-1-3 356 2431 4673

X 2431 4673

1968-1-3 356 2431 4673

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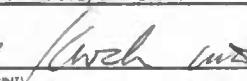
1968-1-3 356 2431 4673

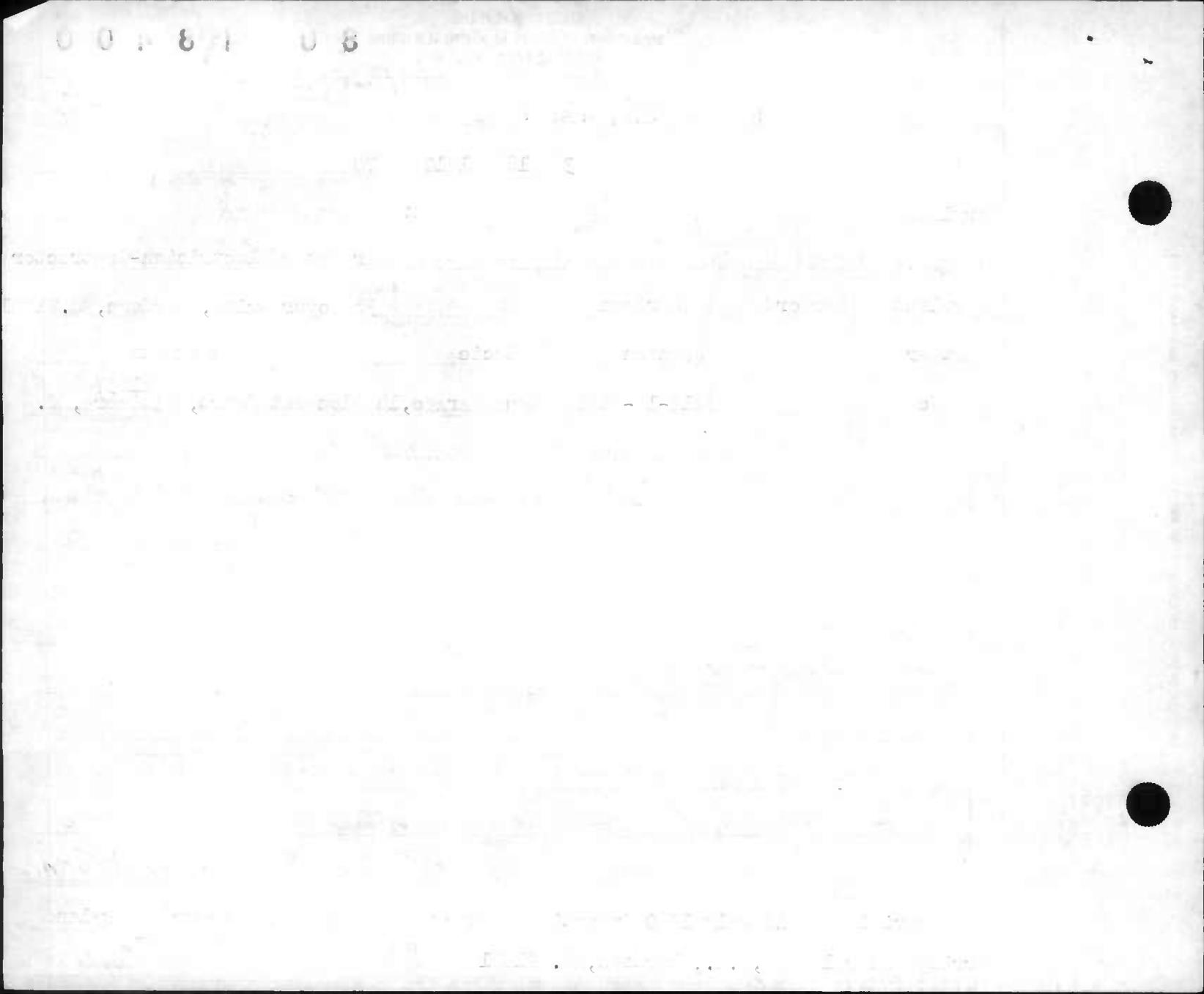
1968-1-3 356 2431 4673

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	0	1	8	4	0
												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH				MONTH	DAY	YEAR	2b. HOUR			
Orrie Edward Johnson							July 13 1980							7:17 M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)				7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.				
Male		White		3 18 1910			70 YRS.										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. DATE OF DEATH			9. BALTIMORE CITY OR COUNTY OF DEATH				MD.						
Maryland		USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			Harford										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Havre de Grace		Harford Memorial Hospital		Carpenter/Electrician-Contractor													
13a. STATE Maryland		13b. COUNTY Harford		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 36 Moyer Drive, Aberdeen, Md. 21001										
14. FATHER'S NAME FIRST Arthur		MIDDLE Johnson		15. MOTHER'S MAIDEN NAME FIRST Lucie			16. ADDRESS 21237										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-18-9082		17. INFORMANT Mona Farago, 11 Glenwest Court, Baltimore, Md.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinomatosis, gen metastasis</u> 1639 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bronchogenic Ca. advanced PLL prae</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congestive Heart Failure &amp; Respiratory failure</u>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 16.																	
18a. DATE OF OPERATION None			18b. CONDITION FOR WHICH OPERATION WAS PERFORMED			18c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 7/13/80					
22b. SIGNATURE 			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HENRY H. KWAY			22e. ADDRESS 437 GIRARD ST, HAVRE DE GRACE														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 16 July 1980			23c. NAME OF CEMETERY OR CREMATORIAL Spesutia Cemetery			23d. LOCATION CITY OR TOWN Perryman		COUNTY Harford	STATE Maryland					
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, Md. 21001			25a. ADDRESS Tarring Funeral Home, P.A., Aberdeen, Md. 21001			25b. DATE REC'D. BY REGISTRAR JUL 17 1980			25c. REGISTRAR'S SIGNATURE 								



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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8018401		
1 - STATE REGISTRAR			REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2d. HOUR		
ERNASTINE Lois Jones						July 27 80						18 <sup>60</sup> M		
3. SEX			4 RACE	5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
Female			White	May 29, 1916			64							
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.		
VA.			USA						Harford					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY					
Harford			Hartford Memorial Hosp			Housewife								
13a STATE			13b COUNTY	13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS			2300 Calvary Road		
Md.			Harford	Bel Air					XXXXXXXXXXXXXXXXXXXX					
14 FATHER'S NAME			FIRST	MIDDLE	LAST	15 MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST			
James			--		Lambert	Emma			Kate		Leftwich			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO			231-18-0830			Donald L. Jones, Box 123 Belcamp, Md.						Sudden		
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			4292			DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V.D. & T.I.A. 10 days			DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Atherosclerosis ?					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			Abdominal aortic aneurysm											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from show the deceased alive on			7-17 19 80			to 7-27 19 80			that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE			EDWARD C. LOO, MD			DEGREE			22c. DATE SIGNED			9/27/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY				
Burial			July 30, 1980	BelAir Mem. Gardens			Bel Air			Harford			Md.	
24 FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Howard K. McComas III, Abingdon, Md.						JUL 29 1980			Henry McComas					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8018402			
										REG. NO.			
1. FOR STATE REGISTRAR			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	7-27-80			12	49	PM		
John PAUL Jones													
3 SEX			4 RACE		5 DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male			Cauc.		MONTH / DAY YEAR		78 YRS.			MONTHS	DAYS	HOURS	MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			HARFORD MD.			
N.C.			U.S.										
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
FALLSTON			FALLSTON General Hosp.			retired FORESTER - State Govt.							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. STREET ADDRESS	
			Md.			HARFORD			DARLINGTON			4318 Conowingo Road	
14 FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
John FRANKLIN JONES						ANNA			Lou		GTEET		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT(S) 838-4197 ADDRESS			42 EAST JARRETTSVILLE Road				
YES - MATINES			217-12-9839-A			Mr. John Paul JONES, Jr.			FOREST HILL, Maryland 21050				
PART 1. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)			Acute myocardial Infarction										
410 - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) CARDIAC Arrest										
			DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  None													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED  WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a I certify that (I) (this hospital) attended the deceased from 7/26 19 70 to 7/27 19 80, that (I) (we) lost the deceased alive on 7/26 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
27a. SIGNATURE  Stephen M. Pollock			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7/27/80				
21d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen M. Pollock			22e. ADDRESS Fallston General Hospital										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE July 30, 1980			23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gardens			23d. LOCATION CITY OR TOWN Bel Air, Harford Co., Maryland 21014			COUNTY	STATE
24. FUNERAL DIRECTOR Joseph William Foster Joseph William Foster			ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014			25a. DATE REC'D. BY REGISTRAR JUL 30 1980			25b. REGISTRAR'S SIGNATURE jones				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 8 4 0 3

1. DECEASED-NAME (Type or print)		First <b>ADAM</b>	Middle <b>JAMES</b>	Lost <b>KEITHLEY</b>	2a. DATE OF DEATH Month <b>7</b>	Day <b>23</b>	Year <b>80</b>	2b. HOUR <b>A 10:50</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	S. DATE OF BIRTH <b>9/13/1893</b>			6. AGE (In years last birthday) <b>86</b>	IF UNDER 1 YEAR MONTHS <b>YRS.</b>	IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>HARFORD CO.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>HARFORD COUNTY, Md.</b>		
10. CITY OR TOWN OF DEATH <b>HAVRE DE GRACE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>BREVIN NURSING HOME, INC., FARMER</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>FARMER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Agric.</b>
13a. USUAL RESIDENCE (Where deceased admission) STATE <b>MD.</b>		13b. COUNTY <b>HARFORD</b>		13c. CITY OR TOWN <b>Havre de Grace</b>		13d. INSIDE CITY LIMITS? <b>YES</b>	13e. STREET AND NUMBER <b>1808 OLD XANX BIBBER RD.</b>	1400 Revolution St.
14. FATHER'S NAME First <b>COLEMAN</b>		Middle <b>Amos</b>	Lost <b>KEITHLEY</b>	15. MOTHER'S MAIDEN NAME First Middle <b>LAURA</b>		VIRGINIA CULLUM		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-32-0001</b>		17. INFORMANT <b>M. GRACE KEITHLEY, 100 REVOLUTION ST.</b>		Address <b>H.de G., MD.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio respiratory failure</b> <b>5500</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular d</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes Mellitus</b>								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>J. T. Lee</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>7/28/80</i>			
22d. PHYSICIAN'S NAME (Type) <i>J. T. Lee M.D.</i>		22e. ADDRESS <i>Cokesbury U. Methodist Union Med. clinic. Abingdon, Harford Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>July 26, 1980</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Cokesbury U. Methodist</b>			23d. LOCATION (City or Town) (County) (State) <b>Abingdon Harford Md.</b>		
24. FUNERAL DIRECTOR <b>Howard K. McComas III, Abingdon, Md.</b>		ADDRESS			25a. REC'D. BY REGISTRAR <b>JUL 25 1980</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

08235.00

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 80118404					
1- STATE REGISTRAR			2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR OF ESTI- DEATH MATED 0725 1980 745 M														
1. DECEASED NAME (TYPE OR PRINT) Kong			FIRST MIDDLE LAST			2b. HOUR 28. HOUR 745 M											
3. SEX M			4. RACE Chinese			5. DATE OF BIRTH MONTH DAY YEAR 8 14 16			6. AGE (IN YEARS AS OF BIRTHDAY) 63 YRS.			7. IF UNDER 1 YR. MONTHS DAYS			8. IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) China			7b. CITIZEN OF WHAT COUNTRY? China			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.								
10. CITY OR TOWN OF DEATH Fallston			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance			12b. KIND OF BUSINESS OR INDUSTRY Restaurant								
13a. STATE Md			13b. COUNTY Harford			13c. CITY OR TOWN Belair			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 700 E MacPhail Rd					
14. FATHER'S NAME FIRST Unk			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST Unk			MIDDLE			LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-92-7542			17. INFORMANT Daughter: ADDRESS Belair, MD 21014			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
												DUE TO, OR AS A CONSEQUENCE OF (b) Arterio-sclerotic heart Disease					
												DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: History of Gastrointestinal bleeding																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE Willard R Amoss						TITLE (SPECIFY) Asst Dir M.D.			MEDICAL EXAMINER			DATE SIGNED 7/26/80					
EXAMINER'S NAME (TYPE OR PRINT) Willard R Amoss			ADDRESS 2404 Pleasantville Rd, Fallston MD														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/30/80			23c. NAME OF CEMETERY OR CREMATORIAL Lorraine Park Cemetery			23d. LOCATION CITY OR TOWN Woodlawn, Balto. Co., MD			COUNTY STATE					
24. FUNERAL DIRECTOR NAME STEWART & MOWEN CO., 108 W. North Ave.			ADDRESS 21201			25a. DATE REC'D. BY REGISTRAR JUL 30 1980			25b. REGISTRAR'S SIGNATURE Shirley Kennedy								

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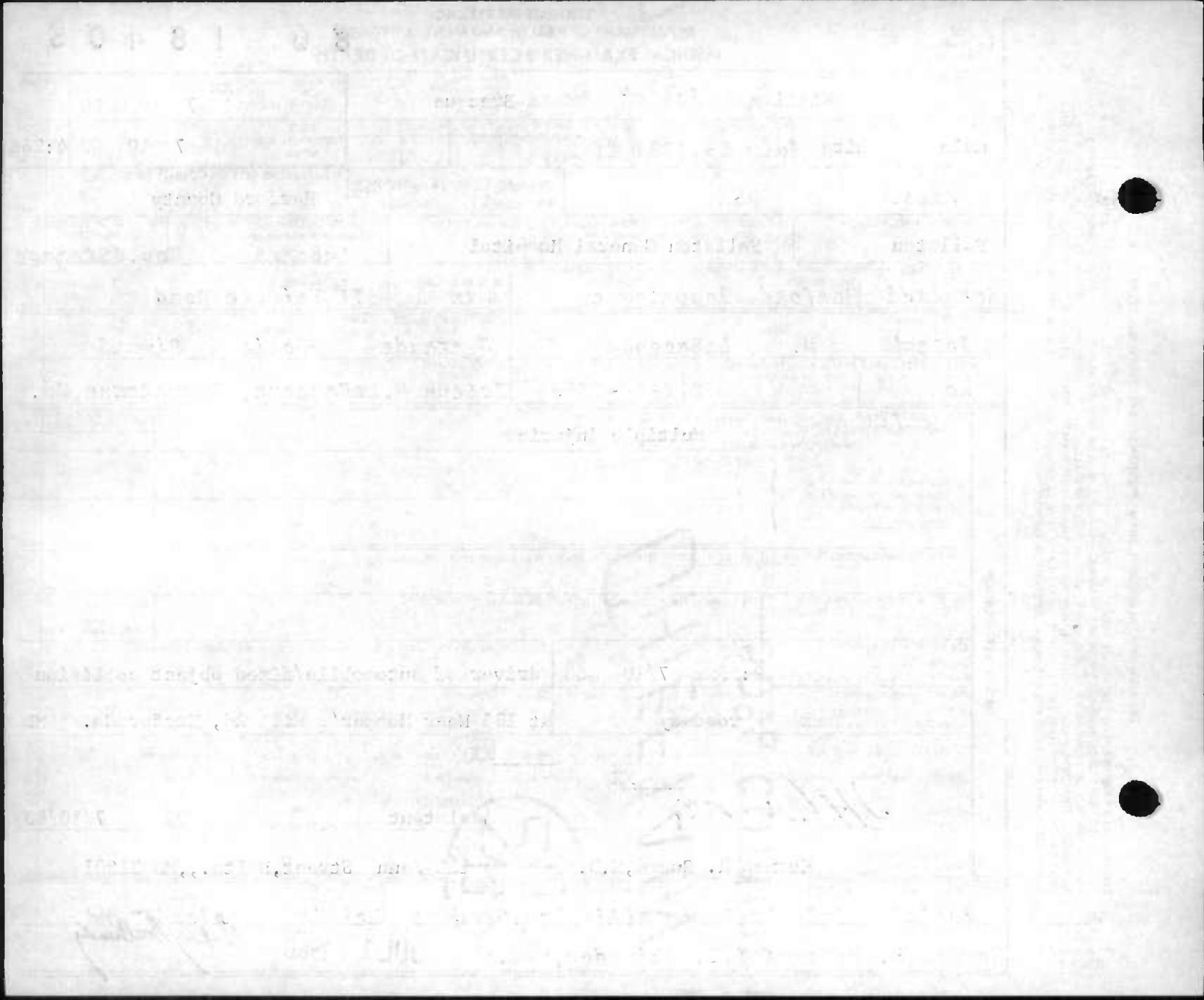
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**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 8018405		
1. DECEASED NAME (TYPE OR PRINT)			FIRST William	MIDDLE Joseph	LAST La Brecque	2a. DATE KNOWN OF DEATH ESTIMATED MATED			MONTH XX	DAY 7	YEAR 10	2b. HOUR 1980 M		
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH July	DAY 23	YEAR 1959	6. AGE (IN YEARS) LAST BIRTHDAY 20 YRS.	IF UNDER 1 YR. MONTHS 0	IF UNDER 24 HRS. HOURS 0	MIN 0	2c. DATE PRONOUNCED DEAD			MONTH 7	DAY 10	YEAR 1980 M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED WIDOWED DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH Harford County					
10. CITY OR TOWN OF DEATH Fallston			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer			12b. KIND OF BUSINESS OR INDUSTRY Mov. & Storage					
13a. STATE Maryland			13b. COUNTY Harford			13c. CITY OR TOWN Joppatowne			13d. INSIDE CITY LIMITS? YES XX NO <input type="checkbox"/>			13e. STREET ADDRESS 671 Trimble Road		
14. FATHER'S NAME FIRST Joseph			MIDDLE M.			LAST LaBrecque			15. MOTHER'S MAIDEN NAME FIRST Gertrude			MIDDLE Doris		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 212-84-7396			17. INFORMANT ADDRESS Joseph M. LaBrecque, Joppatowne, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  8150 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES XX NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:55xx 7/10 1980			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver of automobile/fixed object collision								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK XX			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway			21f. LOCATION STREET Rt 136 Near Hooker's Mill Rd, HarfordCo.			CITY OR TOWN Rt 136 Near Hooker's Mill Rd, HarfordCo.	COUNTY HarfordCo.	STATE MD			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE <i>Hormez R. Guard</i>			TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER			DATE SIGNED 7/10/80					
EXAMINER'S NAME (TYPE OR PRINT)			Hormez R. Guard, M.D.			ADDRESS 11 Penn Street, Balto., MD 21201								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE July 12, 1980			23c. NAME OF CEMETERY OR CREMATORIUM BelAir Mem. Gardens			23d. LOCATION CITY OR TOWN BelAir					
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR 'JUL 15 1980			COUNTY Harford Co.					



**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

**TO FUNERAL DIRECTOR** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

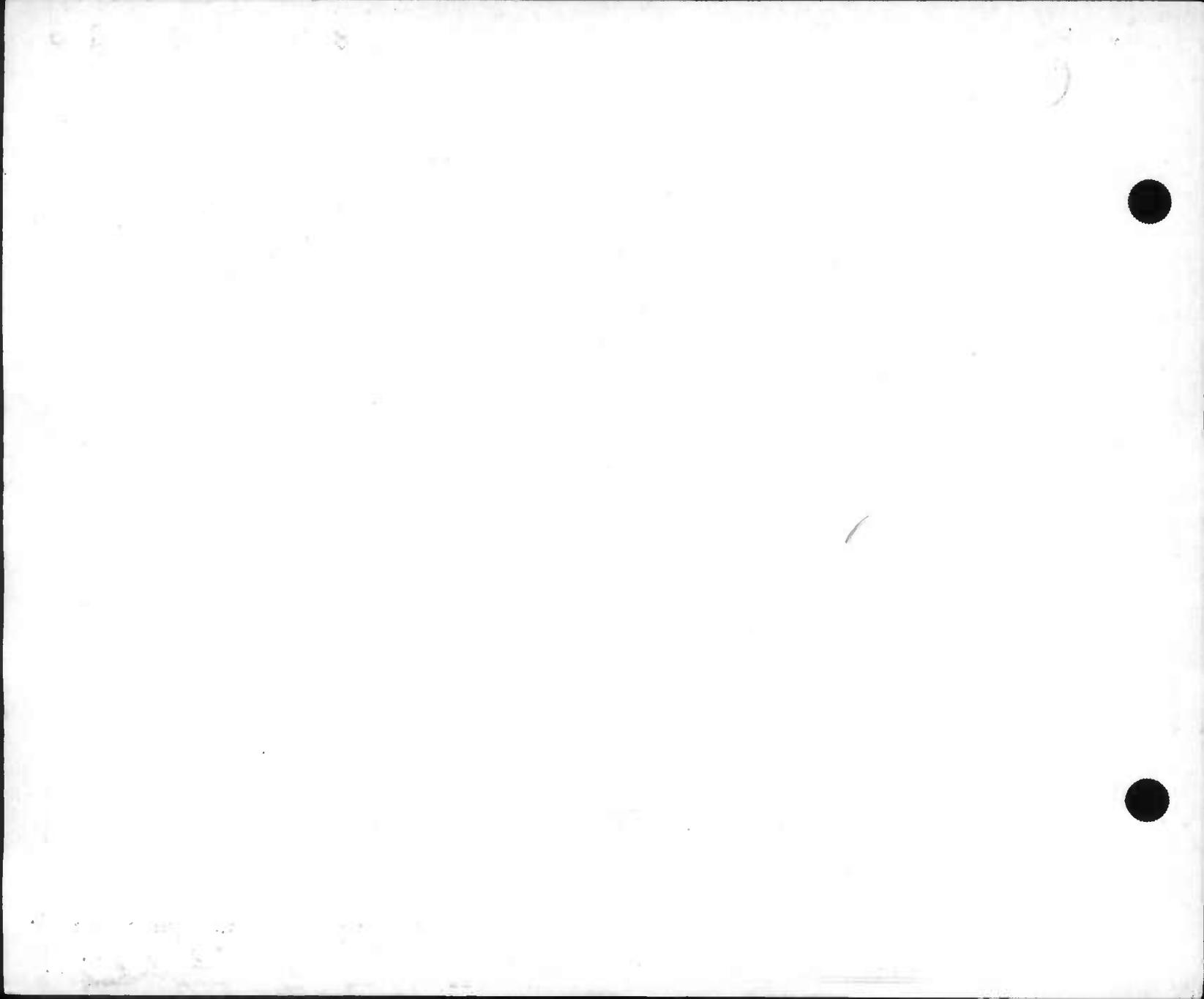
Item 5 g546 8/1/80 gj

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

8 0 1 8 4 0 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Viola	MIDDLE B.	LAST Liller	2a DATE OF DEATH MONTH DAY YEAR July 21, 1980	2b HOUR 8 40 AM
3 SEX Female	4 RACE White	5 DATE OF BIRTH Oct 14 1993	6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b CITIZEN OF WHAT COUNTRY? USA	8 BALTIMORE CITY OR COUNTY OF DEATH Harford MD.					
10 CITY OR TOWN OF DEATH Harre de Grace	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY		
13a STATE MD	13b COUNTY Harford	13c CITY OR TOWN Aberdeen	13d INSIDE CITY LIMITS? YES XX NO <input type="checkbox"/>	13e STREET ADDRESS 446 Bernice Terrace			
14. FATHER'S NAME FIRST Grant	MIDDLE Dorwart	LAST	15. MOTHER'S MAIDEN NAME FIRST Mary	MIDDLE	LAST Baker		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b SOCIAL SECURITY NO No 172-05-8902D	16c INFORMANT Paul J. Liller 1635 Esbenshade Rd., Lancaster	ADDRESS	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks			
18 CAUSE OF DEATH (Enter only one cause per line for Part 1a), and PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac decompensation</i>			DUE TO, OR AS A CONSEQUENCE OF (b) <i>A. S. C.V.D.</i>	?			
			DUE TO, OR AS A CONSEQUENCE OF (c) <i>-</i>				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Senility</i>							
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET	CITY OR TOWN	COUNTY	STATE		
22a I certify that (I) (this hospital) attended the deceased from <i>July 1</i> , 1980, to <i>July 21</i> , 1980, that (I) (we) last saw the deceased alive on <i>July 21</i> , 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	22b. SIGNATURE <i>Edward C. Loo, M.D.</i> DEGREE EDWARD C. Loo, M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22c DATE SIGNED <i>7/21/80</i>							
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Edward C. Loo, M.D.</i>	22e ADDRESS <i>Harre de Grace, Ind. 21078</i>						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7-24-80	23c NAME OF CEMETERY OR CREMATORIAL Riverview Burial Park	23d. LOCATION CITY OR TOWN Lancaster	23e COUNTY City Lanc. Co., Pa.	23f STATE Pa.		
24 FUNERAL DIRECTOR NAME J.J. Hartenstein	ADDRESS New Freedom, PA	25a. DATE REC'D. BY REGISTRAR JUL 31 1980	25b. REGISTRAR'S SIGNATURE <i>Peter J. Hartenstein</i>				

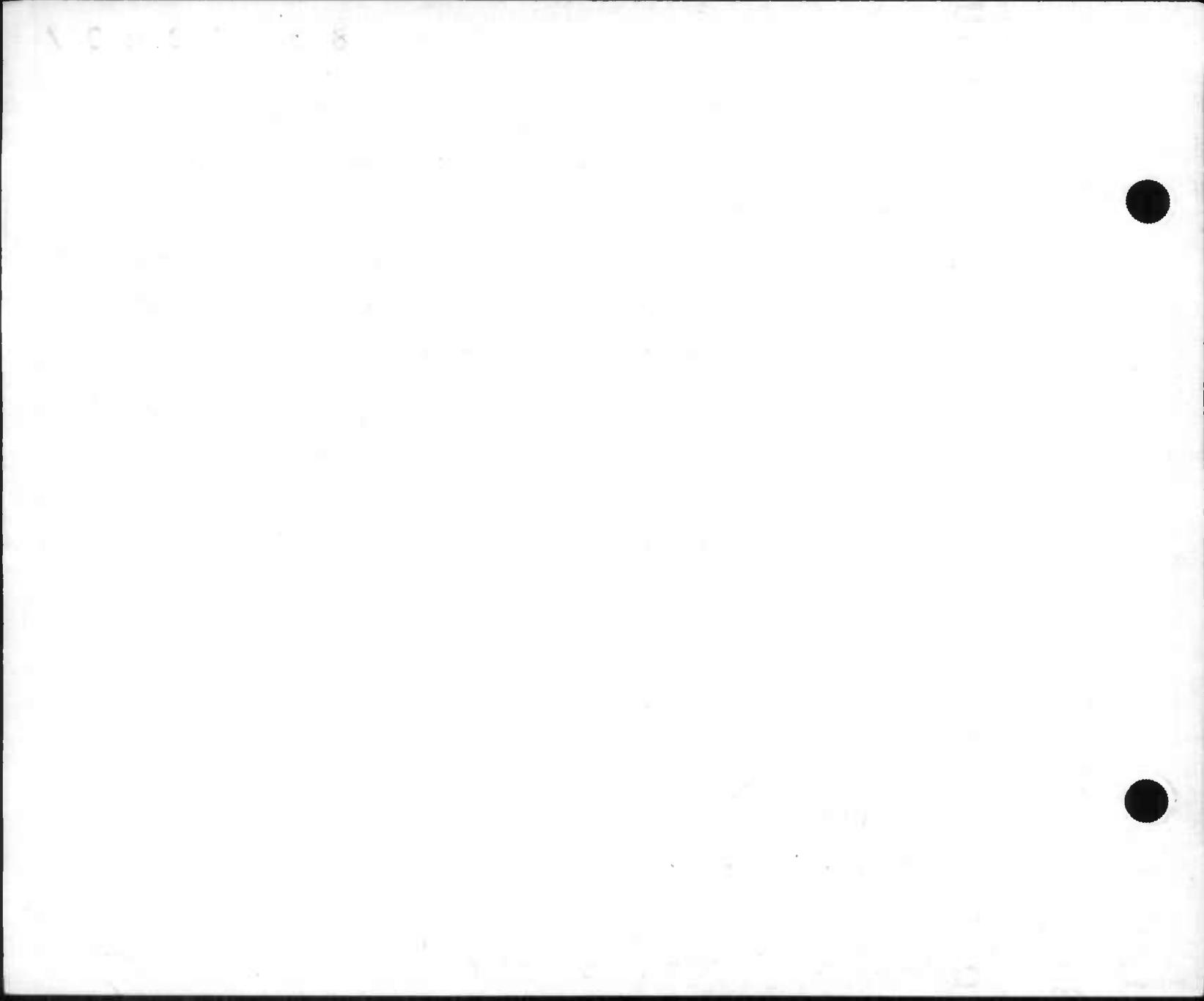


TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG NO	80 18407		
1 - STATE REGISTRAR			1 DECEASED NAME FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
(TYPE OR PRINT)			Elizabeth B. Sidney Lilly				July 8, 1980			30 2 PM			
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR IF UNDER 24 HRS			
Female		White		Sept. 20, 1914			65 YRS.			MONTHS DAYS HOURS MIN			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Harford			MD.			
10 CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital					12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY HOMEMAKER			
13a. STATE Maryland		13b. COUNTY Harford Co.		13c. CITY OR TOWN Bel Air			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 801 Cashew Court - Apt. D			
14. FATHER'S NAME FIRST Clyde		MIDDLE Gray		15. MOTHER'S MAIDEN NAME FIRST LENORA			16. SOCIAL SECURITY NO. 22-09-1185			17. INFORMANT (Husband) 838-9011 ADDRESS 801 Cashew Ct. - Apt. D Mr. Elbert G. Lilly, Sr. Bel Air, Maryland 21014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> 5314 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Hypovolemia or Anemia</i> (c) <i>Active bleeding from both gastro &amp; duod</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION STATED IN PART 1(a) <i>Pulmonary carcinoma with rib erosion</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>7/7</u> , 19 <u>80</u> , to <u>7/8</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.												22c. DATE SIGNED July 8, 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles J. Foley, Jr. MD/PA		22e. ADDRESS Havre de Grace, Md. 21078				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 10, 1980		23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gardens			23d. LOCATION CITY OR TOWN Bel Air, Harford Co., Maryland, 21014			COUNTY STATE			
24. FUNERAL DIRECTOR Joseph William Foster Glenville Falls		25a. ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014		25b. REC'D. BY REGISTRAR JUL 14 1980			25c. REGISTRAR'S SIGNATURE Mary McCreary						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.				
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b. HOUR				
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			July 22, 1980 3:55 P.M.								
THOMAS HALL LOCHARY														
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
MALE		White		6 18 11			69							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH				MD.			
Maryland		U.S.A.					Harford Co.							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Fallston		Fallston General Hospital.		Truck Driver			Oil Delivery							
13a. STATE		13b. COUNTY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS							
Maryland		Harford Co.		Fallston			411 Wilgis Road							
14 FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME										
Joseph Gallion		SUSAN MAGDALENE HARKINS												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17 INFORMANT (Daughter) 8177-3656 ADDRESS										
No		218-03-0112		Mrs. Linda C. Bond			503 Wilgis Road Fallston, Maryland 21047							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
4992		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		ASCVHD			26 minutes							
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR — P.M. — 19 —		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE		22c. DEGREE		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED							
Dean L Vassar		MD					7/22/80							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		2003 Rock Spring Rd, Forest Hill, Maryland 21050										
Burial		July 25, 1980		Bel Air Memorial Gardens			Bel Air, Harford Co., Maryland 21014							
24. FUNERAL DIRECTOR Joseph William FOSTER		ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
				JUL 25 1980			Patsy McCreary							

603108

Pd 11 31 a 24.0W

pd portrait x A.Z.W. Judgment

crooked nos. round soft hooked nose with nostril notched

hump slightly 112 x Goblet w hump Judgment

wide mouth with nostril notched

hump slightly 112 x Goblet w hump Judgment

wide mouth with nostril notched

hump slightly 112 x Goblet w hump Judgment

wide mouth with nostril notched

hump slightly 112 x Goblet w hump Judgment

wide mouth with nostril notched

hump slightly 112 x Goblet w hump Judgment

wide mouth with nostril notched

hump slightly 112 x Goblet w hump Judgment

wide mouth with nostril notched

hump slightly 112 x Goblet w hump Judgment

wide mouth with nostril notched

hump slightly 112 x Goblet w hump Judgment

wide mouth with nostril notched

hump slightly 112 x Goblet w hump Judgment

wide mouth with nostril notched

TO HOSPITALIZED ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8018409		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH				MONTH	DAY	YEAR	7b. HOUR	
Vivian H. Marshall						July 23 80							8:50 P.M.	
3. SEX			4 RACE	5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female			White	MONTH 4	DAY 15	YEAR 19	61				MONTHS YRS.	DAYS	HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH				
MD			USA							HARFORD MD.				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY				
Havre de Grace			HARFORD Memorial Hospital			School Teacher								
13a. STATE			13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS			
Pa.			Chester	Nottingham							310 State Line Rd.			
14. FATHER'S NAME			FIRST Cecil	MIDDLE	LAST HILL	15. MOTHER'S MAIDEN NAME				FIRST Billian	MIDDLE	LAST Adeline	GRUBB	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No			219 18 2312											
18. CAUSE OF DEATH (Enter only one cause per line for 18a, b, and c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												months		
1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												Metastatic Carcinoma		
18b. DUE TO, OR AS A CONSEQUENCE OF (b) Colon and bone CA												of 6 mos		
18c. DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 7-23 1980 to 7-23 1980, that (I) (we) last saw the deceased alive on 7-23 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (if we did not) view the body after death.														
22b. SIGNATURE M. Jadowsky MD			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 7/23/80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Jadowsky MD			22e. ADDRESS 504 Lewis St. Havre de Grace Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 7/24/80			23c. NAME OF CEMETERY OR CREMATORIAL Balto., Md.				23d. LOCATION CITY OR TOWN COUNTY STATE				
24 FUNERAL DIRECTOR NAME Anatomy Board			ADDRESS			25a. DECEASED BY JUL 30 1980				25b. REGISTRAR'S SIGNATURE John J. Murphy				

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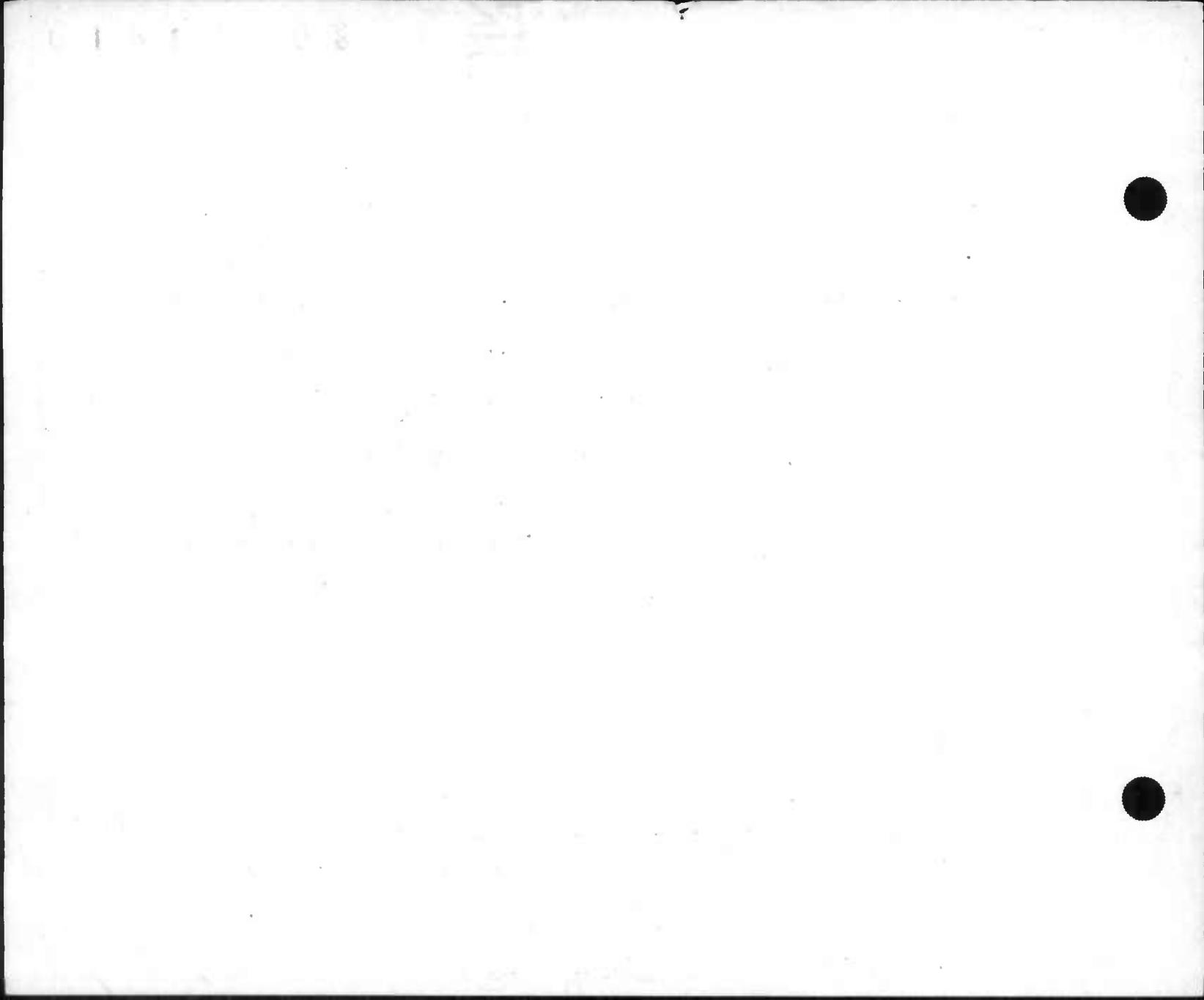
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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8018410			
												REG. NO.			
1 - FOR STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE OF DEATH MONTH DAY YEAR			2b HOUR 11:55 PM			
			<i>Hollis (nmn)</i>			<i>Martin</i>			7 8 80						
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY) YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
<i>male</i>		<i>White</i>		<i>April 5, 1911</i>			<i>69</i>								
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.					
<i>Maryland</i>		<i>USA</i>					<i>Harford County</i>								
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
<i>Fallston</i>		<i>Fallston General Hospital</i>										<i>Electrician</i>		<i>Tool</i>	
13a STATE		13b COUNTY		13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS					
<i>Maryland</i>		<i>Harford</i>		<i>Bel Air</i>						<i>950D Redfield Road</i>					
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST			
<i>Howard</i>		<i>Wilson</i>		<i>Martin</i>			<i>May</i>					<i>Pyle</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT			ADDRESS								
<i>NO</i>		<i>219-03-0132</i>		<i>Mrs. Helen Naomi Martin, Bell Air, Md.</i>											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Massive Brain damage</i>													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Cardiac arrest</i> DUE TO OR AS A CONSEQUENCE OF (c) <i>Hypertensive Artherosclerotic heart disease</i> DUE TO OR AS A CONSEQUENCE OF															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Bronchopneumonia</i>															
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED							20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a I certify that (i) this hospital attended the deceased from _____ 19_____, to _____ 19_____, that (ii) (we) last saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (ii) (we) (did) (did not) view the body after death.															
22b SIGNATURE <i>Henry W. K. Kim, MD</i>													DEGREE		
22c PHYSICIAN'S NAME (TYPE OR PRINT) <i>HENRY W. KIM</i>													ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22d ADDRESS <i>801 S. Union Av. Harford Grace, Md.</i>													DATE SIGNED <i>July 9, 80</i>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE				
Burial		<i>July 11, 1980</i>		<i>Centre U.M. Cemetery</i>			<i>Forest Hill-Harford-Md.</i>								
24 FUNERAL DIRECTOR NAME		ADDRESS		25. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <i>Randy Kelley</i>								
Howard K. McComas III, Abingdon, Md.															
DHMH-16 20M (VRA 15, 4) 7/78															
BP _____															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE REGISTRAR			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 80 1.8411			
1. DECEASED NAME (TYPE OR PRINT)			LAST			2d. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Arthur L. McEwing						July 1, 1980					45
3 SEX <b>Male</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>SEPT 26 1910</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b>		IF UNDER 1 YEAR MONTHS <b>YRS.</b>		IF UNDER 24 HRS MONTHS DAYS HOURS MIN <b>12 PM</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Hanford</b>				
10. CITY OR TOWN OF DEATH <b>Havre de Grace</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Hanford Memorial Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CLERK</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>LIQUOR DISPENSING</b>				
13a. STATE <b>MD</b>	13b. COUNTY <b>HARFORD</b>	13c. CITY OR TOWN <b>HAVRE de GRACE</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>801 S. WASHINGTON ST.</b>				
14. FATHER'S NAME FIRST <b>JAMES</b>		MIDDLE <b>U.</b>	LAST <b>MC EWING</b>	15. MOTHER'S MAIDEN NAME FIRST <b>ANNE</b>		MIDDLE	LAST <b>FULTON</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-03-8012</b>			17. INFORMANT <b>BESSIE E. REASIN</b>		ADDRESS <b>SAME AS #13e</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Failure</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5715 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Liver cirrhosis</b>											
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Fracture, Subtrochanteric</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Fracture, Subtrochanteric</b>											
19a. DATE OF OPERATION <b>6/8/80</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Subtrochanteric fracture left</b>			20b. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>6:30 AM 6/7/80 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>Patient fell on left hip</b>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>McDonalds Restaurant</b>			21f. LOCATION STREET <b>504 Lewis St.</b>		CITY OR TOWN <b>Havre de Grace, Md.</b>	COUNTY <b>21078</b>	STATE <b>MD</b>		
22a. I certify that (I) (this hospital) attended the deceased from <b>June 7, 1980</b> to <b>July 1, 1980</b> , that (I) (we) lost the deceased alive on <b>July 1, 1980</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>ASL Seelby</b>		22c. DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <b>7/1/80</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT S. BONNER</b>		22e. ADDRESS <b>504 Lewis St., Havre de Grace, MD</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>3 JULY 1980</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>ANGEL HILL CEMETERY</b>		23d. LOCATION CITY OR TOWN <b>Havre de Grace, HARFORD, MD</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 8 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Mitchell Funeral Home</b>	
24. FUNERAL DIRECTOR NAME <b>Mitchell Funeral Home</b>		ADDRESS <b>Havre de Grace, MD</b>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, plus 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at all times.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8018412										
												REG. NO.										
1 - STATE REGISTRAR				2a DATE OF DEATH				MONTH	DAY	YEAR	2b HOUR											
I. DECEDENT NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	7-6-80				142 AM											
JOSEPH PATRICK MCGRATH				JOSEPH	PATRICK	MCGRATH																
3 SEX		4 RACE		5 DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)														
MALE		W		MONTH	DAY	YEAR	79				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN											
2a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH				12b. KIND OF BUSINESS OR INDUSTRY										
Missouri		USA						HARFORD				Construction										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										
FALLSTON		FALLSTON GENERAL HOSPITAL										Electrician										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS										
Maryland		Harford		Bel Air								407 Plumtree Road										
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME																	
		Patrick	J.	McGrath	Elizabeth																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO		17. INFORMANT				ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
NO		490-03-7965		William A. Holt, Bel Air, Md.								30 days										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																						
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardio pulmonary arrest</i>																						
436 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																						
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebrovascular accident</i>																						
DUE TO, OR AS A CONSEQUENCE OF (c) <i>cerebrovascular insufficiency</i>																						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Pneumonia</i>																						
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN	COUNTY	STATE									
22a. I certify that (I) (this hospital) attended the deceased from 7-5-80 to 7-6-80, that (I) (we) last saw the deceased alive on 7-6-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																						
22b. SIGNATURE <i>A. B. Martins</i>												DEGREE MD	ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 7-6-80								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS				23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN			
A. B. MARTINS			FALLSTON GEN. HOSP.				Burial				July 8, 1980				Trinity Lutheran Cemetery				Toppa Harford Md.			
24 FUNERAL DIRECTOR NAME			ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REC'D. BY TRUSTEE SIGNATURE											
Howard K. McComas III, Abingdon, Md.							JUL 8 1980								<i>H. K. McComas III</i>							

814810085

EP 100

100% of the time

100% of the time

Based on what I do

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 18413									
1. DECEASED NAME (TYPE OR PRINT)			FIRST William			MIDDLE A			LAST Middleton			2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH DAY YEAR		2b. HOUR 7PM				
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS.			7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN			8c. DATE PRONOUNCED DEAD			MONTH DAY YEAR		2d. HOUR 19 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH												
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY												
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS									
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			ADDRESS						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4140			W.W. II			218-03-7397			Catherine Mann 8363 Hillendale Rd.												
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.						{ DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).												Alcoholism									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?															
									YES <input type="checkbox"/> NO <input type="checkbox"/>												
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE						
22a. I certify that I took charge of the remains described above, held on <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> Undetermined manner												and in my opinion.									
death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE			EXAMINER'S NAME (TYPE OR PRINT)			TITLE (SPECIFY)			M.D.			MEDICAL EXAMINER			DATE SIGNED						
William A. Middleton			William A. Middleton			7/18/80									7/18/80						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			23e. COUNTY			STATE						
Burial			7-21-80			Glen Haven Cemetery			Glen Burnie			A.A.			Md.						
24. FUNERAL DIRECTOR			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE												
John C. Miller Inc.			6415 Belair Rd.			JUL 24 1980															

1961-08-10 08:00-10:00

1961-08-10 10:00-12:00

1961-08-10 12:00-14:00

1961-08-10 14:00-16:00

1961-08-10 16:00-18:00

1961-08-10 18:00-20:00

1961-08-10 20:00-22:00

1961-08-10 22:00-00:00

1961-08-10 00:00-02:00

1961-08-10 02:00-04:00

1961-08-10 04:00-06:00

1961-08-10 06:00-08:00

1961-08-10 08:00-10:00

1961-08-10 10:00-12:00

1961-08-10 12:00-14:00

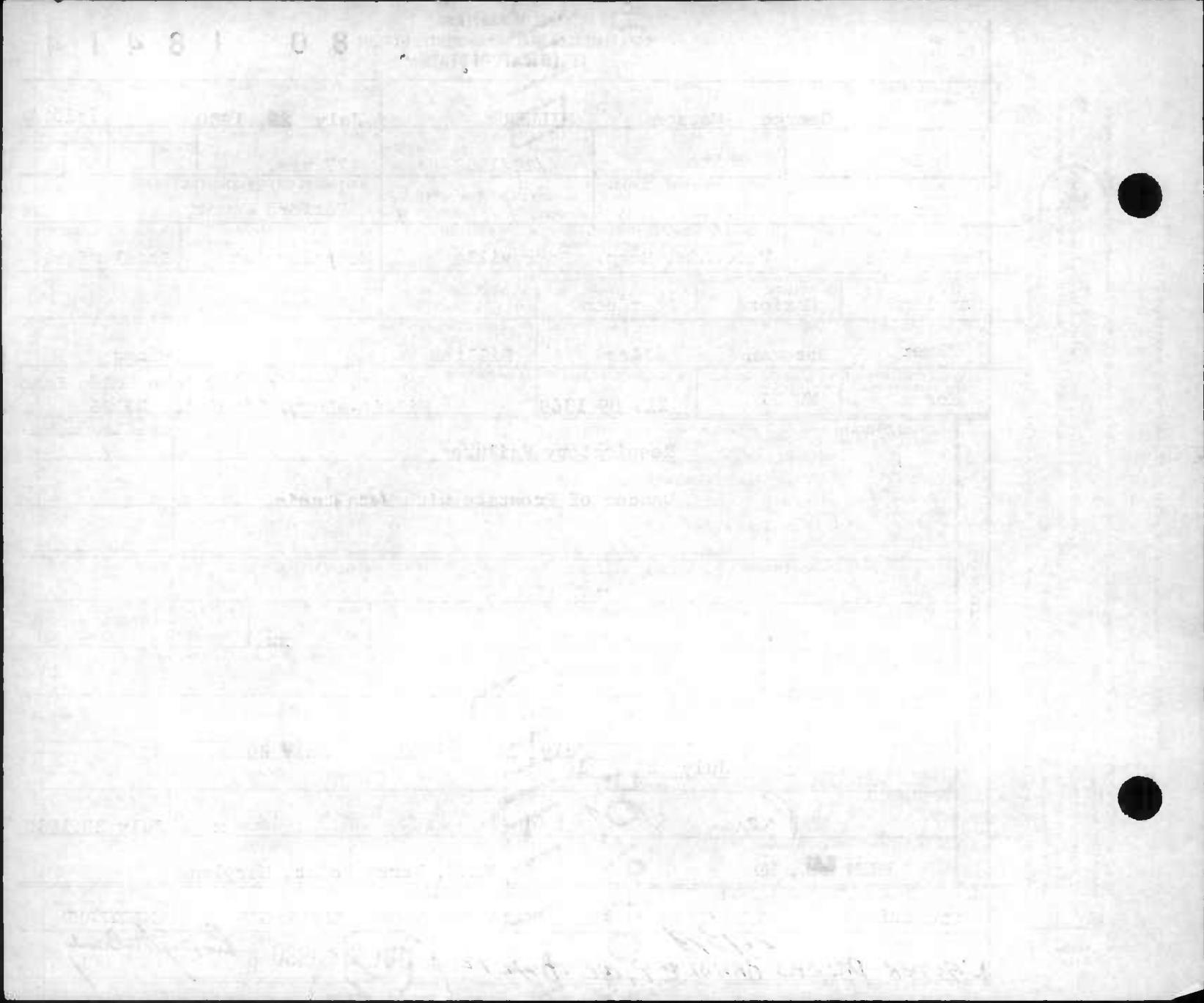
1961-08-10 14:00-16:00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3  
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3  
should be detached for use on the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death  
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0   8 4   4 CERTIFICATE OF DEATH																
REG. NO.																
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
George Watson MILLER												July 20, 1980			7:15 AM	
3. SEX			4. RACE			5. DATE OF BIRTH						6 AGE [IN YEARS LAST BIRTHDAY]			IF UNDER 1 YEAR	
Male			White			MONTH DAY YEAR			4/28/1903			77 yrs.			IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MONTHS DAYS HOURS MIN.	
Maryland			U.S.A.									Harford County			MD.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			13d. INSIDE CITY LIMITS?			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Perryville			Vet. Adm. Hosp., Perryville			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Metallurgist			Steel Mfgr.				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13e. STREET ADDRESS			12c. ADDRESS				
Maryland			Harford			Aberdeen			418 Stepney Rd.			John A. Purdie 180 John Rolfe Lane				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME													
FIRST Elmer MIDDLE Baseman LAST Miller			FIRST Lillian MIDDLE Owings													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Yes WW II			213 09 1369						John A. Purdie 180 John Rolfe Lane			Williamsburg, Virginia 23185				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>185-</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cancer of Prostate with Metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last { DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from July 14, 1980, to July 20, 1980, that (I) (we) last saw the deceased alive on July 20, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>Prem Lal, M.D.</i>			DEGREE			22c. DATE SIGNED										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PREM LAL, MD			ATTENDING MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>						July 20, 1980							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 7/21/1980			23c. NAME OF CEMETERY OR CREMATORIAL GREEN MOUNT CREMATORIAL			23d. LOCATION CITY OR TOWN BALTIMORE			COUNTY		STATE		
24. FUNERAL DIRECTOR NAME <i>WALTER BROOKS BRADLEY, INC. BALTO</i>			ADDRESS			25a. DATE REC'D. BY REGISTRAR JUL 24 1980			25b. REGISTRAR'S SIGNATURE <i>Walter Brooks Bradley</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as "Yes" Item 18 shows any injury, or other traumatic event; the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8018415
												REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
Julia C. Halk					Miller	July 26 80			45 12 PM			
3. SEX			4 RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS, LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Female			White	10 10 30 1901			78					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD			
10. CITY OR TOWN OF DEATH HAURE DE GRACE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION HARFORD MEMORIAL HOSP			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Clerk			12b. KIND OF BUSINESS OR INDUSTRY B&O Railroad			
13a. STATE Md			13b. COUNTY HARFORD	13c. CITY OR TOWN Aberdeen	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 12 NEAST RD. APT 2A				
14. FATHER'S NAME THOMAS			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME DeLIA			LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 705-05-4920			17. INFORMANT William P. Miller, Apt. 2A, 12 N. East Rd., Aberdeen			ADDRESS Maryland 21001			
18. CAUSE OF DEATH (Enter only one cause per line, if 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			Cardiogenic Shock						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs.			
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost			Due to, or as a consequence of (b)			Cardiac Decompensation 6 days						
			Due to, or as a consequence of (c)			A.S.C.V.D + Subendocardial infarction 6 days						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)			Hyp. S. C.V.D. + Rheumatoid Arthritis									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> HOME <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE			
22a. I certify that (b) this hospital attended the deceased from <u>July 21 1980</u> to <u>July 26 1980</u> that (1) (we) last saw the deceased alive on <u>July 26 1980</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did / did not view the body after death.												
22b. SIGNATURE Edward C. Loo, MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED July 26, 1980			
THE PHYSICIAN'S NAME (TYPE OR PRINT) Edward C. Loo, MD			22d. ADDRESS Haure de Grace, Md. 21078									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 29 July 80			23c. NAME OF CEMETERY OR CREMATORIUM Parkwood Cemetery			23d. LOCATION CITY OR TOWN Baltimore			
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, Md. 21001			25a. ADDRESS Tarring Funeral Home, P.A., Aberdeen, Md. 21001			25b. DATE REC'D. BY REGISTRAR JUL 30 1980			25c. REGISTRAR'S SIGNATURE Henry M. Miller			

2025 RELEASE UNDER E.O. 14176

188 DE JUL.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR RECORDS.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS OF DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

1- STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 8 4 1 6

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Benjamin</i>	MIDDLE <i>Joseph</i>	LAST <i>Mitchell</i>	2a. DATE KNOWN OF DEATH ESTIMATED	MONTH <i>7</i>	DAY <i>19</i>	YEAR <i>1980</i>	2b. HOUR <i>11:00 AM</i>			
3. SEX <i>M</i>	4. RACE <i>Caucasian</i>	5. DATE OF BIRTH MONTH <i>5</i>	DAY <i>10</i>	YEAR <i>1901</i>	6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>79</i>	IF UNDER 1 YR. MONTHS <i>0</i>	IF UNDER 24 HRS. DAYS <i>0</i>	HOURS <i>0</i>	MIN <i>0</i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		2c. DATE PRONOUNCED DEAD		MONTH <i>7</i>	DAY <i>19</i>	YEAR <i>1980</i>		
10. CITY OR TOWN OF DEATH <i>Norrisville</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>5214 West Heaps Road</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Machinist</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Fool &amp; Dye</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i>				
13a. STATE <i>MD</i>		13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Fawn Grove</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>5214 West Heaps Rd. Fawn Grove, Pa.</i>				
14. FATHER'S NAME FIRST <i>Peter</i>		MIDDLE <i></i>	LAST <i>Mitchell</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Ida</i>		MIDDLE <i>S</i>	LAST <i>Hill</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>165-18-1568</i>		17. INFORMANT <i>Agnes Fahnestock</i>		ADDRESS <i>Fawn Grove, Pa.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
<i>4140</i> Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		{ DUE TO, OR AS A CONSEQUENCE OF <i>Arteriosclerotic Heart Disease</i>										
(b) DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>Hirsch Hernia</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?						
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural cause <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Willard P. Amoss</i>		TITLE (SPECIFY) <i>Asst. Dep. Medical Examiner</i>		DATE SIGNED <i>7/19/80</i>								
EXAMINER'S NAME (TYPE OR PRINT) <i>Willard P. Amoss</i>		ADDRESS <i>2404 Pleasant Valley Rd., Fallston, Md. 21047</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE <i>7/23/1980</i>		23c. NAME OF CEMETERY OR CREMATORIAL St. Marys Cemetery		23d. LOCATION CITY OR TOWN <i>Rylesville, Harford, Md.</i>		COUNTY STATE				
24. FUNERAL DIRECTOR NAME <i>M. G. Kurtz III</i>		ADDRESS <i>Jarrettsville, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>JUL 22 1980</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>						

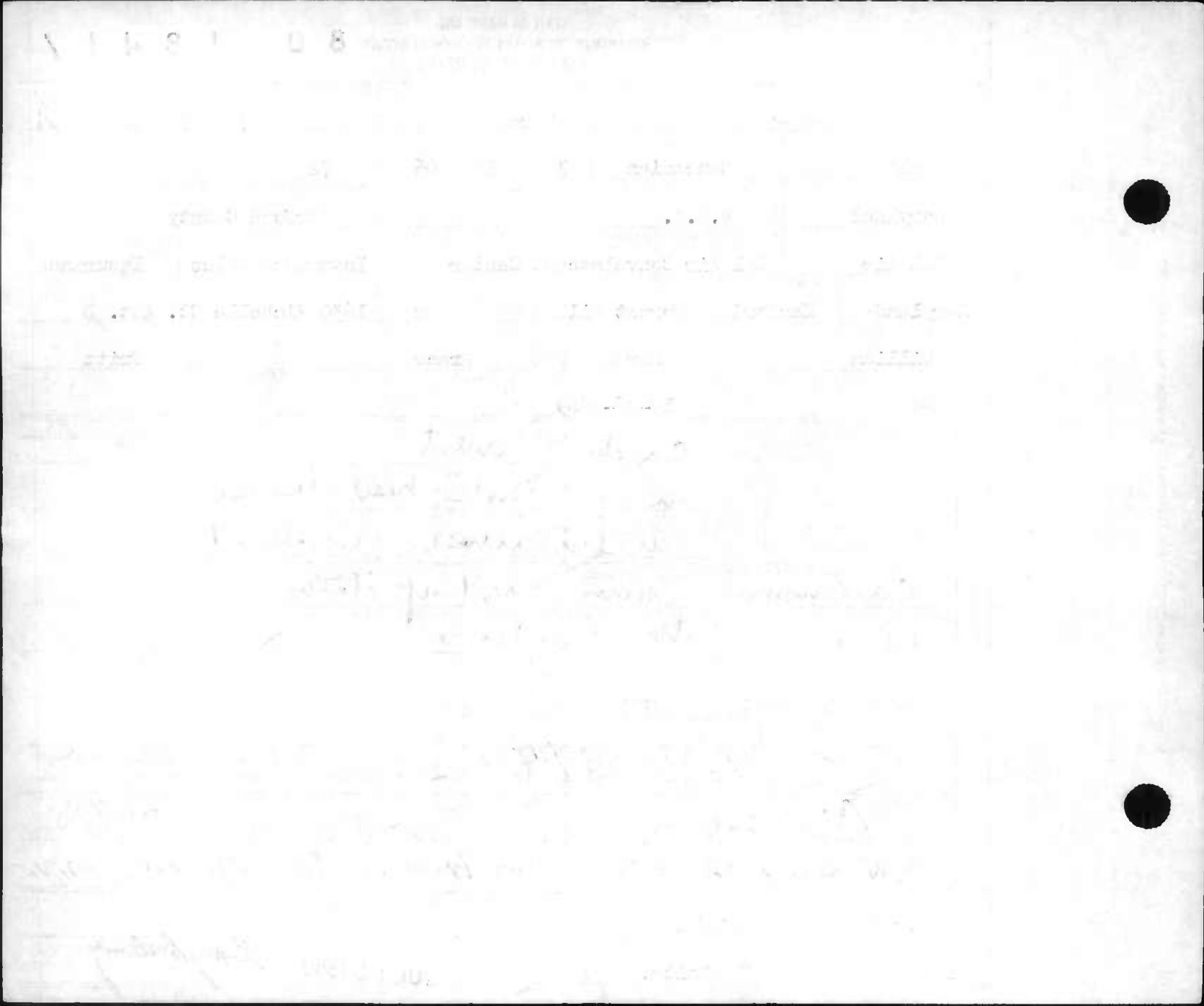


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 8 4 1 7 CERTIFICATE OF DEATH														
REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR <i>9:34 AM</i>	
<i>Robert E. Moran</i>					<i>Moran</i>			7		5	80			
3. SEX			4 RACE	5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
<i>Male</i>			<i>Caucasian</i>	<i>12 18 06</i>			<i>72</i>							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			Harford County MD.		
<i>Maryland</i>			<i>U.S.A.</i>						<i>Harford County</i>			<i>Insurance Sales Insurance</i>		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
<i>Bel Air</i>			<i>Bel Air Convalescent Center</i>			<i>Insurance Sales</i>			<i>Insurance</i>					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		
<i>Maryland</i>			<i>Harford</i>			<i>Forest Hill</i>						<i>1630 Michelle Ct. Apt. D</i>		
14. FATHER'S NAME FIRST			MIDDLE	LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST			
<i>William</i>				<i>Moran</i>			<i>Grace</i>				<i>Fritz</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS					
<i>No</i>			<i>219-06-8689</i>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <i>cardiac arrest</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) <i>arteriosclerotic heart disease</i>														
{ DUE TO, OR AS A CONSEQUENCE OF (c) <i>arteriosclerosis, generalized</i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Carcinoma colon. put up notes</i>														
19a. DATE OF OPERATION <i>1976</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>colon cancer</i>			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>5/14/78</i> , 19 <i>80</i> , to <i>7/5</i> , 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>7/14/80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>BEN STEYER</i>			22c. DEGREE			ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>7/5/80</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>BEN STEYER M.D.</i>			22e. ADDRESS <i>1131 Baltimore Pike Bel Air, Md 21020</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>			23b. DATE <i>7/5/80</i>			23c. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN			23d. LOCATION CITY OR TOWN					
24. FUNERAL DIRECTOR NAME <i>Anatomy Board</i>			ADDRESS <i>Baltimore, Md.</i>			25a. DATE REC'D. BY REGISTRAR <i>July 15 1980</i>			25b. REGISTRAR'S SIGNATURE <i>John J. Murphy</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8018418			
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2b HOUR							
Louis Arthur Robertson						July 13 1980 3 09 PM							
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN.	
Male		White		Oct. 5, 1919			60 YRS						
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nebraska		7b CITIZEN OF WHAT COUNTRY? USA		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Harford					MD.	
10 CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plastics Tech.			12b KIND OF BUSINESS OR INDUSTRY US-govt. Ret.						
13a STATE Maryland		13b COUNTY Harford		13c CITY OR TOWN Aberdeen			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 506 N. Paradise Road			
14 FATHER'S NAME Louis Arthur Robertson		15. MOTHER'S MAIDEN NAME Florene Ruthruf											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. WWII		17 INFORMANT Mrs. Carmelita Robertson, Aberdeen, Md.									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		18b APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		18c DUE TO, OR AS A CONSEQUENCE OF (b)									
				18d DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE								
22a I certify that (I) (this hospital) attended the deceased from 7-13 1980 to 7-13 1980, that (I) (we) lost sow the deceased alive on above, (I) (we) (did) (did not) view the body after death													
22b SIGNATURE Brian T. Yeo, MD		22c DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d DATE SIGNED 7-14-80								
22e PHYSICIAN'S NAME (TYPE OR PRINT) Brian T. Yeo, MD		22f ADDRESS Havre de Grace, Md.											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE July 15, 1980		23c NAME OF CEMETERY OR CREMATORIAL Westview Crematory, Baltimore			23d LOCATION CITY OR TOWN COUNTY STATE						
24 FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md.		25a DATE REC'D. BY REGISTRAR JUL 16 1980			25b REGISTRAR'S SIGNATURE Potter Melody								

8 1 2 3 4 5 6 7 8

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 18419	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTIMATED			MONTH	DAY	YEAR	2b. HOUR 6:20 AM	
Marion A. Schmidt						<input checked="" type="checkbox"/>			July	13	1980		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR M	
F	Cauc	1 15 99	81			<input checked="" type="checkbox"/>			19				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH							
Md.		U.S.A.				Harford County							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Fallston		Fallston General Hospital				Homemaker							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		7 Forest Drive			
Md.		Harford		Bel Air		<input type="checkbox"/>		7		Forest Drive			
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST					
Robert		T.	Anderson	Edna					Milburn				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
no		213-48-1088		Mrs. Elizabeth M. Trezise		Forest Dr.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
{ DUE TO, OR AS A CONSEQUENCE OF Axteriosclerotic Heart Disease													
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?				
									<input type="checkbox"/> YES <input type="checkbox"/> NO				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		Willard F Amoss										TITLE (SPECIFY)	
												M.D. Asst Dep.	
EXAMINER'S NAME (TYPE OR PRINT)		Willard F Amoss										MEDICAL EXAMINER	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL				23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE	
Burial		7-15-80		Parkwood Cem.				Balto.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
John C. Miller Inc.		6415 Belair Rd.		JUL 16 1980		Mary Murphy							

6 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
<i>Edward Gilbert Shifflett, Sr.</i>			<i>Gilbert</i>		<i>Shifflett, Sr.</i>	<i>July 2, 1980</i>				<i>3:30 PM</i>		
3. SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR				6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2b. HOUR			
<i>Male</i>	<i>White</i>	<i>May 2, 1926</i>				<i>54</i>	MONTHS	DAYS	MONTHS	HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.				
<i>Va.</i>	<i>U.S.A.</i>				<i>Harford</i>							
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
<i>Havre de Grace</i>	<i>Harford Mem Hospital</i>					<i>Trimmer</i>			<i>Tree</i>			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS						
<i>Md</i>	<i>Harford</i>	<i>Joppa</i>				<i>305 Philadelphia Rd.</i>						
14 FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			16. SOCIAL SECURITY NO			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
<i>Junior Franklin Shifflett</i>			<i>Blanche M. Mowbray</i>			<i>29-30-94 86</i>			<i>3 mo.</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						
<i>Yes</i>	<i>WWII</i>					<i>From Adenoc. of Common duct - obstructive</i>						
1561 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) <i>acute renal - hepatic failure</i>			DUE TO, OR AS A CONSEQUENCE OF (c) <i>Fistula, biliary - pancreatic,</i>			<i>janeous</i>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
<i>June 3, 1980</i>	<i>AdenoCa of Common duct - obstructive</i>					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			<i>fatality</i>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>5/28, 1980</i> to <i>7-2, 1980</i> , that (I) (we) last saw the deceased alive on <i>7-2, 1980</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
<i>HENRY H. KWAN</i>											<i>7/2/80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			22f. ADDRESS		22g. ADDRESS					
<i>HENRY H. KWAN</i>		<i>437 GIRARD ST Havre de Grace</i>			<i>21078</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY	STATE			
Burial		<i>July 5, 1980</i>	<i>BelAir Mem. Gardens</i>			<i>Bel Air Harford</i>		<i>Md.</i>				
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
<i>Howard K. McComas III Abingdon, Md.</i>					<i>JUL 3 1980</i>		<i>Henry H. Kwan</i>					

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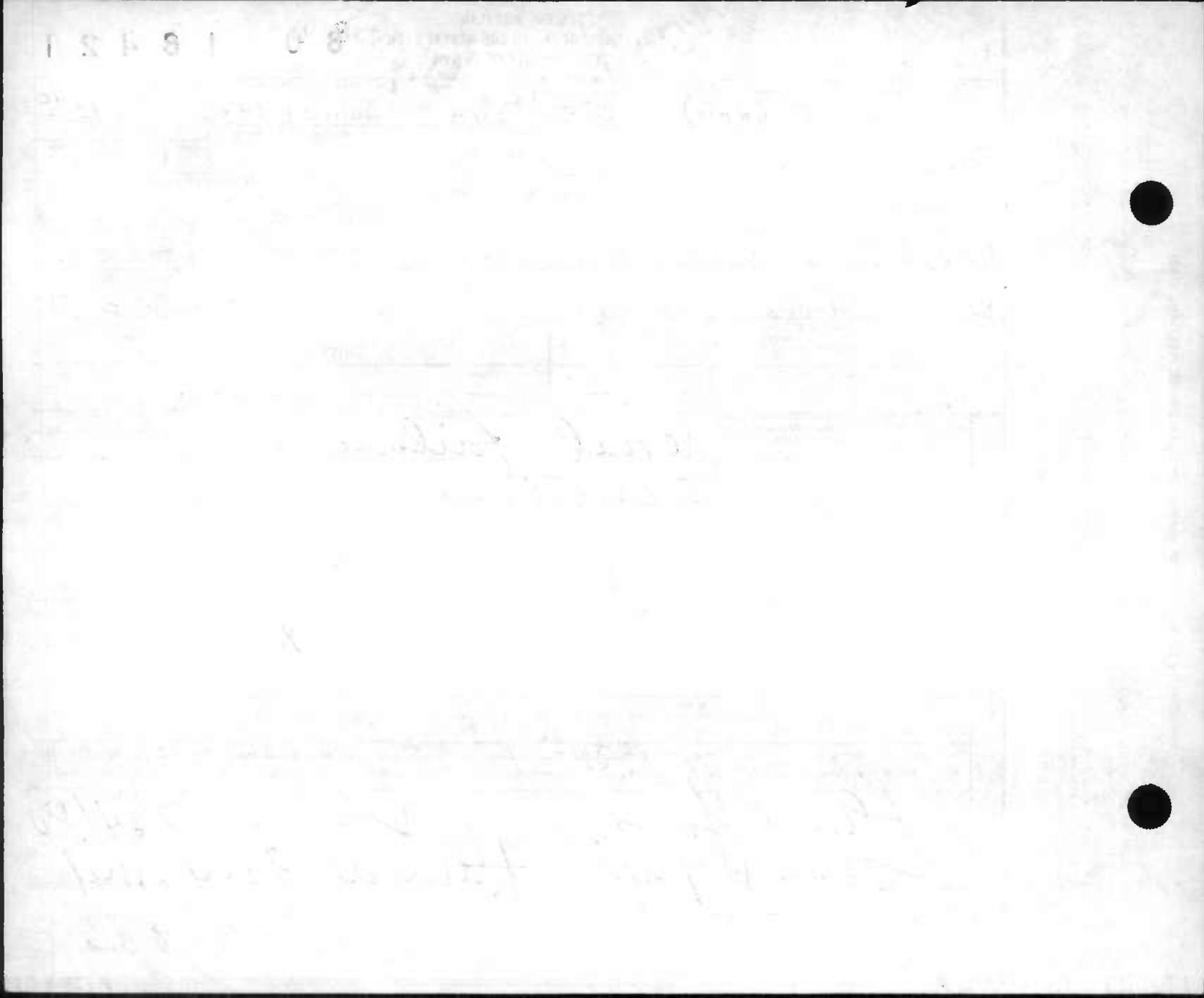
1000 1000 1000 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8018421		
										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) <b>AND/OR LOUISE (NMS) ALOISIE (NM)</b>					2a DATE OF DEATH LAST STREET <b>STREIT TOVA</b>					2b HOUR 12:40 AM		
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>MAY 19, 1900</b>			6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	2b. HOUR HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>CZECHOSLOVAKIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <b>HARFORD</b>		MD.			
10 CITY OR TOWN OF DEATH <b>Hause de Grace</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HARFORD Memorial Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FINISHER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>SHOE MFGR.</b>					
13a STATE <b>MD</b>		13b COUNTY <b>HARFORD</b>		13c. CITY OR TOWN <b>Abingdon</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>3806 Christine Drive (L) \$</b>			
14 FATHER'S NAME FIRST <b>UNKNOWN</b>		MIDDLE <b>UNKNOWN</b>		LAST			15. MOTHER'S MAIDEN NAME FIRST <b>UNKNOWN</b>		MIDDLE <b>UNKNOWN</b>		LAST	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. <b>215.32.4174</b>		17 INFORMANT <b>HENRY W. STREIT (SAME AS 13e)</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>586 - renal failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>586 - renal failure</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (his hospital) attended the deceased from <b>July 21, 1980</b> to <b>July 26, 1980</b> , that (I) (we) last saw the deceased alive on <b>July 24, 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										22b SIGNATURE <b>Joun D Yun</b>		
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joun D Yun</b>		22d. DEGREE <b>MD</b>		22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22f. DATE SIGNED <b>7/24/80</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>7/25/1980</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>GREEN MOUNT</b>			23d. LOCATION CITY OR TOWN <b>BALTIMORE</b>		23e. COUNTY <b>MARYLAND</b>			
24. FUNERAL DIRECTOR NAME <b>WALTER BROOKS BRADLEY, INC., BALTO., MARYLAND</b>		25. DATE REC'D. BY REGISTRAR <b>JUL 30 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Walter Brooks Bradley</b>								
BP _____		ADDRESS										
DHMH-16 25M (VRA 15, 4) 1/79												

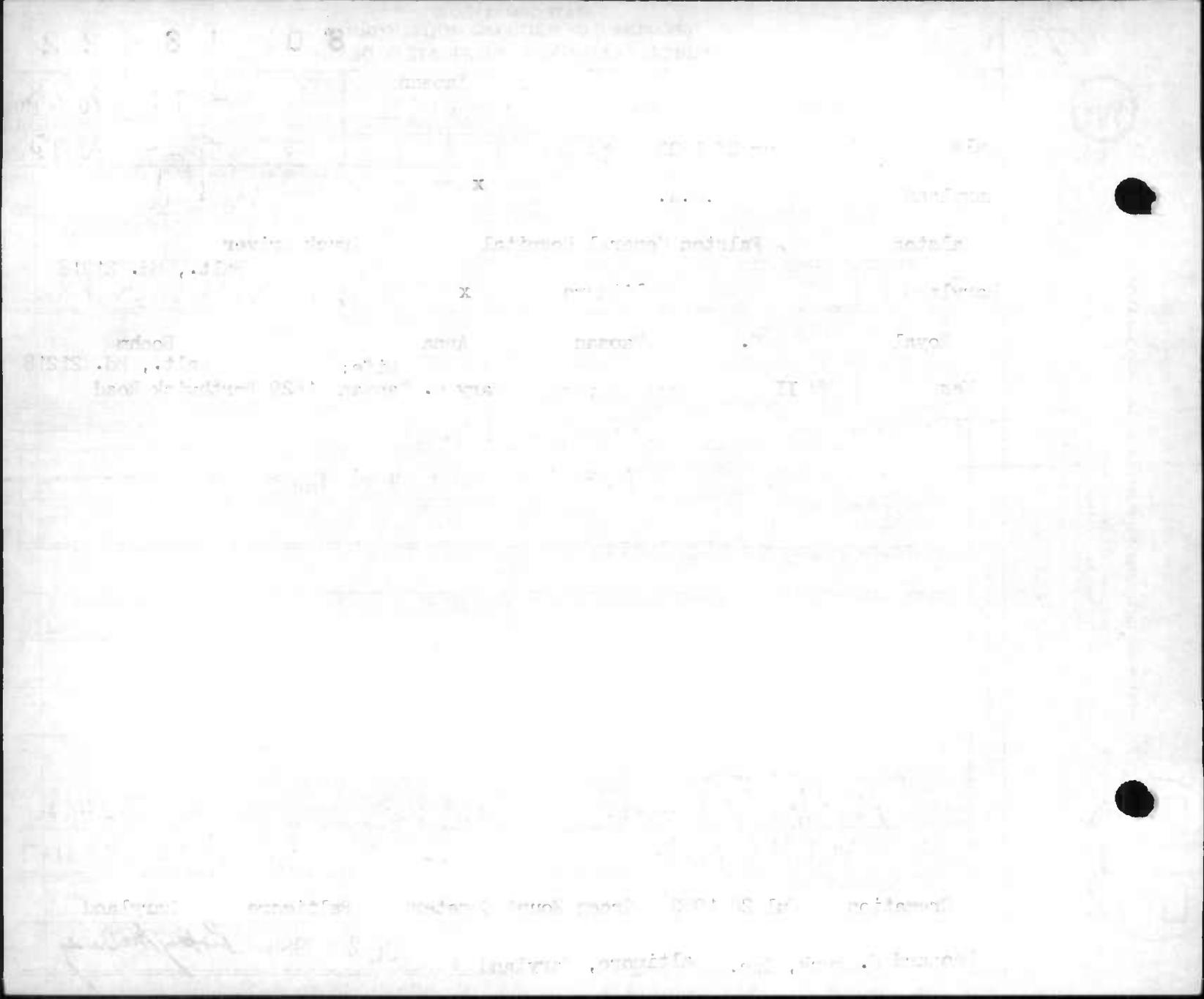


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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. PAGE 3 RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED (WITHIN 72 HOURS AFTER DEATH), WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 8018422
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>George</i>	MIDDLE <i>Boehm</i>	LAST <i>Tapman</i>	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH <i>July</i>	DAY <i>24</i>	YEAR <i>1980</i>	2b. HOUR <i>6 PM</i>
3. SEX <b>Male</b>		4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Aug 25 1922</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>57 yrs.</b>		IF UNDER 1 YR. <input checked="" type="checkbox"/>	IF UNDER 24 HRS. <input type="checkbox"/>	MONTH <b>57</b>	DAYS <b>0</b>	HOURS <b>0</b>	MIN <b>0</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Harford</b>		
10. CITY OR TOWN OF DEATH <b>Falston</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Falston General Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Truck Driver</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Balt., Md. 21218</b>				
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1629 Northwick Rd.</b>						
14. FATHER'S NAME FIRST <b>Royal</b>		MIDDLE <b>C.</b>	LAST <b>Tapman</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Anna</b>			MIDDLE <b></b>	LAST <b>Boehm</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW II 215-16-7959</b>		17. INFORMANT <b>Wife: Mary E. Tapman</b>			ADDRESS <b>Balt., Md. 21218</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  4140 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF Atherosclerotic Heart Disease (c) DUE TO, OR AS A CONSEQUENCE OF												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) STREET CITY OR TOWN COUNTY STATE						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Willard P. Amoss</i> TITLE (SPECIFY) M.D. <i>Asst Reg</i> MEDICAL EXAMINER DATE SIGNED <i>7/24/80</i>												
EXAMINER'S NAME (TYPE OR PRINT) <b>Willard P. Amoss</b>			ADDRESS <b>2404 Pleasantville Rd. Falston MD 21047</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Jul 28 1980</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>Green Mount Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Baltimore</b>		COUNTY <b>Maryland</b>	STATE			
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc.</b>			ADDRESS <b>Baltimore, Maryland</b>			25a. DATE REC'D. BY REGISTRAR <b>JUL 28 1980</b>		25b. REGISTRAR'S SIGNATURE <i>Lori McCreedy</i>				
DHMH - 17 (VR A15 ME(5)) 15M 7/77												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8018423				
1 - STATE REGISTRAR			REG. NO.													
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR				
Clarence William Taylor						Oct. 9, 1980			7	4	80	6:40 P.M.				
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			# UNDER 1 YEAR		# UNDER 24 HRS				
Male		White		Oct. 9, 1916			63			YEARS	MONTHS	DAYS	HOURS	MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Va.		USA					HARFORD									
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY				
Havre de Grace			HARFORD Memorial Hospital						Truck Driver			Concrete				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS			
			MD			HARFORD		Bel Air					2319 Churchville Road			
14 FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST							
Andy			--	Taylor	Lora			--	Hart							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17 INFORMANT			ADDRESS							
No			230-10-3998			David A. Taylor, Bel Air, Md.										
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 410- Acute Inf wall MI.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 hours				
DUE TO, OR AS A CONSEQUENCE OF (b) Rupture - failure																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
									YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN	COUNTY	STATE					
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c DATE SIGNED 7/14/80				
22b. SIGNATURE <i>B. Parekh MD.</i>			DEGREE MD.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. Parekh MD.			22e ADDRESS 622 S. Union Ave, Havre De Grace.													
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE July 8, 1980			23c. NAME OF CEMETERY OR CREMATORIAL G Cemetery Oak Grove Baptist			23d. LOCATION CITY OR TOWN Bel Air Harford			COUNTY	STATE			
24 FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md.			ADDRESS			25a DATE REC'D. BY REGISTRAR JUL 7 1980			25b. REG. NO. Signature <i>Larry McComas</i>							

68681 08

adult - positive probab.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 0 1 8 4 2 4	
												REG. NO.	
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			Weldon M. Taylor						July 20, 1980			6:20 PM	
3. SEX			4 RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Male			White			July 16, 1928			52				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Maryland			U.S.A.						Harford County				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY				
Edgewood			1954 Melvin Dr			Mechanic							
13a STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS	
Maryland			Baltimore			Middle River						108 Kingston Park Rd	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
FIRST Weldon MIDDLE H LAST Taylor			FIRST Hazel R MIDDLE Greenwood LAST										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS				
No			217-24-5583			Mrs B. Jean Brown			Same				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u>												8 months	
DUE TO, OR AS A CONSEQUENCE OF (b) _____													
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>obstruction</u>													
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (# EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from <u>NOV 21 BR 1979</u> to <u>JULY 20 1980</u> that (we) lost the deceased alive on <u>7/20 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE <u>Emory S Linder</u>			22c DEGREE <u>M.D.</u>			22d ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e DATE SIGNED <u>7/21/80</u>				
22f PHYSICIAN'S NAME (TYPE OR PRINT) <u>Emory S Linder M.D.</u>			22g ADDRESS <u>902 Averill Rd Joppa, Maryland</u>										
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE <u>7/23/80</u>			23c NAME OF CEMETERY OR CREMATORIAL <u>Moreland Mem Park</u>			23d LOCATION CITY OR TOWN <u>Baltimore, Maryland</u>			COUNTY STATE	
Burial													
24 FUNERAL DIRECTOR NAME			ADDRESS			25a DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Leonard J Ruck Inc. Baltimore, Maryland						JUL 22 1980						<u>Lisette McCreary</u>	

L S 4 6 1 0 8

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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8018425						
										REG. NO.						
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR				
			Leo (mn) Torigian						July 16, 1980			55 11 PM				
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			7 UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN.				
MALE		White		July 15, 1899			81 YRS									
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Mass.		USA					HARFORD									
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY				
HARFORD de GRACE		HARFORD Memorial Hosp.								Painter		St. of Md.				
13a STATE		13b COUNTY		13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS							
Md.		HARFORD		Joppa					2619 Franklinville Rd.							
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST														
unknown		unknown														
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT			ADDRESS									
Yes		WWI		115-07-9467			Mrs. Anna M. Wingate, Joppa, Md.									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>pneumonia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																
496- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost																
(b) <u>Arterio sclerotic cardiovascular</u>																
{ DUE TO, OR AS A CONSEQUENCE OF (c) <u>chronic obstructive pulm. disease</u>																
DUE TO, OR AS A CONSEQUENCE OF																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE										
22a I certify that (I) (this hospital) attended the deceased from <u>7-12</u> , 19 <u>80</u> , to <u>7-16</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>7-16</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b SIGNATURE <u>J. Lee</u>			22c DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d DATE SIGNED <u>21078</u>										
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. Lee</u>			22e ADDRESS <u>So. Union Ave HARFORD de GRACE Md.</u>													
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE July 19, 1980			23c NAME OF CEMETERY OR CREMATORIAL Gardens of Faith			23d LOCATION CITY OR TOWN Baltimore		23e COUNTY Md.		23f STATE			
24 FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md.			25a DATE REC'D. BY REGISTRAR JUL 18 1980			25b REGISTRAR'S SIGNATURE <u>Henry Kelly</u>										
DHMH-16 20M (VRA 15, 4) 7/78																

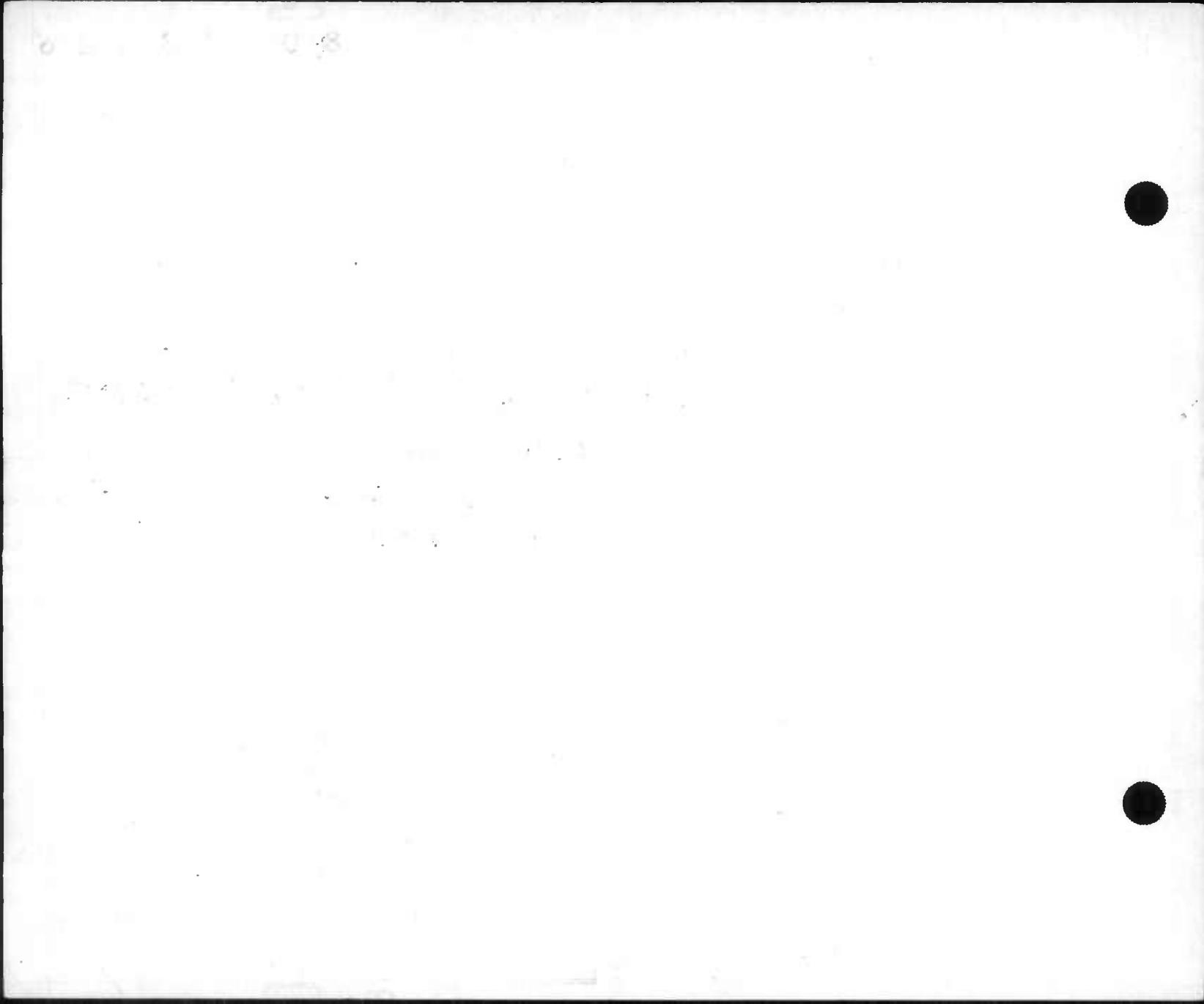


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

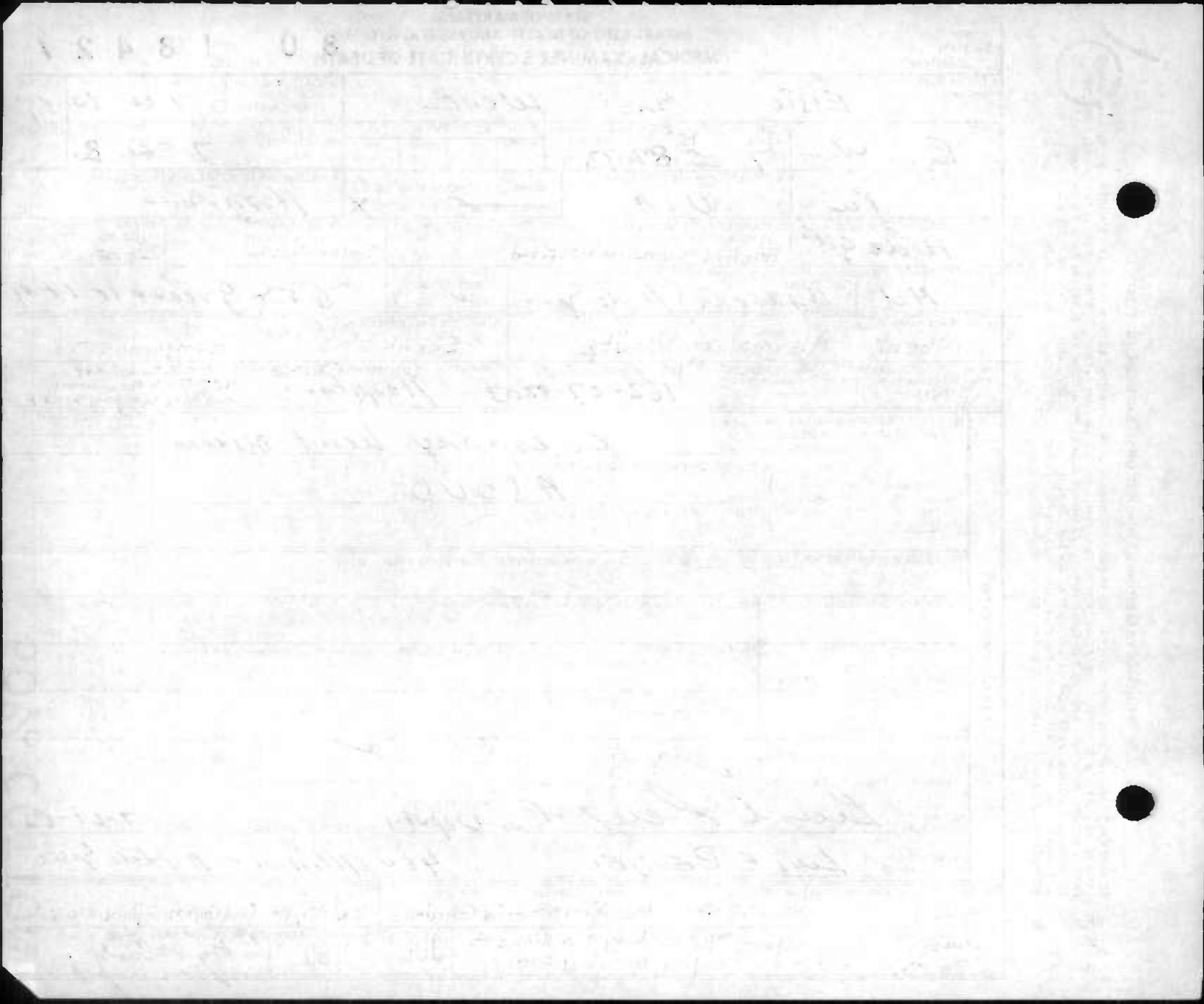
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 0 1 8 4 2 6		
											REG. NO.			
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR		
			William Luther Vaughan						7 25 80			7 15 PM		
3. SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
MALE		White		07 07 01			79 YRS							
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Virginia		U.S.A.					Harford							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY							
Fallston		Fallston General Hospital		Farmer			Agriculture							
13a STATE		13b COUNTY		13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS				
Maryland		Hartford		Bel Air						309 S. Fountain Green Rd				
14. FATHER'S NAME FIRST		MIDDLE		LAST			15 MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST	
George		Ellis		Vaughan			GENETTA						Gilliant	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO		17 INFORMANT (WIFE) 838-9194 ADDRESS						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO		218-14-8932		Mrs. Hazel F. Vaughan 309 South Fountain Green Road										
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))												Thy		
4449 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												year		
DUE TO, OR AS A CONSEQUENCE OF (b))												Severe CAD		
{ DUE TO, OR AS A CONSEQUENCE OF (c))												Atherosclerosis		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												year		
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE									
22a I certify that (I) (this hospital) attended the deceased from 7-3, 1980, to 7-25, 1980, that (I) (we) last saw the deceased alive on 7-25, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED July 25, 1980		
22b. SIGNATURE <i>M. S. Nair</i>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. S. NAIR		22e ADDRESS 1716 Harford Road - Bel Air MD												
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE July 28, 1980		23c NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gardens			23d LOCATION CITY OR TOWN Bel Air Harford Co. Maryland 21014 COUNTY STATE							
24. FUNERAL DIRECTOR John William Foster		ADDRESS W. Broadway & Williams St Bel Air, Maryland 21014		25a DATE REC'D. BY REGISTRAR JUL 29 1980			25b REGISTRAR Linda McElroy							
DMMH-16 20M (VRA 15, 4) 7/78														



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.  
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 18427					
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Elsie</i>	MIDDLE <i>MAE</i>	LAST <i>Wentz</i>	2a. DATE KNOWN OF ESTI- DEATH MATED				MONTH <input type="checkbox"/> JULY DAY <input type="checkbox"/> 22 YEAR <input type="checkbox"/> 1980	2b. HOUR <input type="checkbox"/> 8:06 A.M.						
3. SEX <input checked="" type="checkbox"/> FEMALE		4. RACE <input type="checkbox"/> White	5. DATE OF BIRTH MONTH DAY YEAR <i>7 15 87</i>		6. AGE (IN YEARS (LAST BIRTHDAY) <i>93</i> YRS.	IF UNDER 1 YR. MONTHS <input type="checkbox"/>		IF UNDER 24 HRS. DAYS <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD <i>7-22-80</i>							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pa</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harrowd</i>											
10. CITY OR TOWN OF DEATH <i>Holy Grace</i>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Harrowd Memorial Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Sales Clerk</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Store</i>								
13a. STATE <i>Md.</i>		13b. COUNTY <i>Harrowd</i>		13c. CITY OR TOWN <i>Holy Grace</i>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS <i>634 Greenesr Itcy</i>									
14. FATHER'S NAME FIRST <i>Albert</i>			MIDDLE <i>ALEXANDER</i>	LAST <i>WENTZ</i>	15. MOTHER'S MAIDEN NAME FIRST <i>SARAH</i>			MIDDLE <i>Bungardner</i>	LAST <i>Bungardner</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>182-07-9203</i>			17. INFORMANT (RELATION) <i>Spouse</i>			ADDRESS <i>435 East Broadway Bel Air Maryland 21014</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4140</i> Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. { DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (e).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE <i>Lori E Renzel</i>		TITLE (SPECIFY) <i>Deputy</i>			M.D.			MEDICAL EXAMINER			DATE SIGNED <i>7-23-80</i>						
EXAMINER'S NAME (TYPE OR PRINT) <i>Lori E Renzel</i>			ADDRESS <i>464 Allianc e St Holy Grace</i>			23a. BURIAL/CREMATION/REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>July 25, 1980</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Bel Air Memorial Gardens</i>			23d. LOCATION CITY OR TOWN <i>Bel Air Harrowd Co. Maryland 21014</i>		
24. FUNERAL DIRECTOR <i>Joseph William Foster</i>			ADDRESS <i>W. Broadway &amp; Williams St. Bel Air, Maryland 21014</i>			25a. DATE REC'D. BY REGISTRAR <i>JUL 25 1980</i>			25b. REGISTRAR'S SIGNATURE <i>Patsy McCreary</i>								



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 1 8 4 2 8		
1. DECEASED NAME (TYPE OR PRINT)		FIRST Bobby	MIDDLE -	LAST Womack	2a. DATE KNOWN OF ESTI- DEATH MATED				MONTH JULY	DAY 12	YEAR 1980	2b. HOUR M		
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR June 27, 1956	6. AGE (IN YEARS LAST BIRTHDAY) 24 yrs.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD				MONTH JULY	DAY 12	YEAR 1980	2d. HOUR 4:00 P. M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County				
10. CITY OR TOWN OF DEATH Edgewood		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 755 & Winters Run Bridge				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) E-3				12b. KIND OF BUSINESS OR INDUSTRY U.S. Nat'l. Guard				
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 950 Homestead Street						
14. FATHER'S NAME FIRST Nathaniel		MIDDLE -	LAST Womack	15. MOTHER'S MAIDEN NAME FIRST Mary				MIDDLE -	LAST Patrick					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Active Duty 218-62-3618				17. INFORMANT Debby Womack (Wife) Same as # 13.				ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8151 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. } (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR XX MONTH DAY YEAR 1:30 P.M. 7 12 1980				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) passenger in truck/fixed object impact							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street				21f. LOCATION STREET Rt. 755 & Winters Run Bridge, Edgewood, Har- ford Co., Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accidental <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Thomas D. Smith, M.D.												DATE SIGNED 7-14-80		
EXAMINER'S NAME (TYPE OR PRINT)		Thomas D. Smith, M.D.				ADDRESS 111 Penn Street								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July/18/80		23c. NAME OF CEMETERY OR CREMATORIAL Delaney Valley Mem. Pk.				23d. LOCATION CITY OR TOWN Cockeysville, Maryland				COUNTY	STATE	
24. FUNERAL DIRECTOR NAME Chambers Funeral Home		ADDRESS Riverdale, Maryland				25a. RBO BY REG. STAR JUL 21 1980				25b. REG. STAR'S SIGNATURE				

6 S P 8 1 0 0

Information contained herein is not valid unless confirmed by  
the appropriate authority and current methods.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified in 24 hours.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8018429	REG. NO.			
1 - STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b. HOUR				
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			July 13, 1980 4:50 PM								
2a SEX			4 RACE			5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR			
Female			White			June 29, 1901			79		YRS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH		10 UNDER 24 HRS			
Tenn.			USA						Harford		MONTHS DAYS HOURS MIN			
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY					
Havre de Grace			Harford Memorial Hospital			Housewife			--					
13a STATE			13b COUNTY			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS					
Maryland			Harford			Aberdeen			13 Swan Street					
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT		
Charlie			Eliza			no			215-18-9965			Mrs. Anna Ayers, 412 Stepney Rd.		
18a CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY			18b APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
IMMEDIATE CAUSE (a) 1889 Carcinoma Bladder														
DUE TO, OR AS A CONSEQUENCE OF (b)														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE								
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to July 13, 1980, that (I) (we) last saw the deceased alive on July 13, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) did not view the body after death.														
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED					
Leticia S. Galvez, M.D.			M.D.						7-13-80					
22d PHYSICIAN'S NAME (TYPE OR PRINT)			22e ADDRESS											
LETICIA S. GALVEZ, M.D.			625 S. UNION AVE HAURE DE GR-											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial			July 17, 1980 Calvary U.M. Cem.						Churchville Harford Md.					
24 FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Howard K. McComas III, Abingdon, Md.						JUL 15 1980			Randy McComas					

R E P 8 1 - 0 8

• P. 5000 ft. - dark brown soil  
at 1000 ft. - brown  
soil  
1000 ft. - light brown soil  
at 1000 ft. - brown soil

• 1000 ft. - brown soil